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National Telehealth Coordinators Workshop 2002

Final Report

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Executive Summary

The 2002 National Telehealth Coordinators Workshop was held at the Sheraton Wall Centre in Vancouver, October 1-2, 2002. Sixty telehealth coordinators, representing all regions of the country, were invited to participate. The focus of activities over the two-day workshop was to assemble guidelines and tools to assist in decision-making, promote best practices and improve consistency and efficiency of telehealth service delivery. In each of six subject areas, the following information was collected:

- Best Practices/Guidelines - common approaches and successes
- Lessons Learned - what didn't work and why
- Common Processes for Developing Policy/Guidelines
- Implications for a National Approach
- Outstanding Issues/Constraints
- Action Items/Next Steps

This report summarizes the recommendations developed by the workshop participants in the areas of telehealth consent; patient registration, documentation and records; job descriptions, roles and responsibilities; telehealth awareness and evaluation; telehealth training; and interoperability issues. Full documentation of the proceedings and a summary of action items generated from the recommendations can be found in the appendices.

In addition to the recommendations for guidelines in each of the subject areas, there were several key concluding messages arising from the 2002 National Telehealth Coordinators Workshop. These included the need for more information/input in specific priority areas; the need for more information exchange among telehealth programs/projects; the need for greater networking opportunities among Telehealth Coordinators; the need for a 'voice' representing the Telehealth Coordinators; and the need for some clear paths to escalate issues and action items. To maintain the activity and momentum of the Telehealth Coordinator group, the following initiatives were suggested and should be considered/evaluated for their merits and feasibility:

- The development of a formal Telehealth Coordinators group within CST
- Creation of Special Interest or Working Groups
- Website and other technologies to facilitate networking between Coordinators
- Participation of Telehealth Coordinators in relevant subgroups of other professional organizations (i.e.; Canadian Nurses Association (CNA)
- Future Telehealth Coordinator Workshops

Sommaire

L'atelier national de 2002 des coordonnateurs et coordonnatrices de TéléSanté s'est déroulé au Sheraton Wall Centre, à Vancouver, les 1er et 2 octobre 2002. Soixante coordonnateurs et coordonnatrices de TéléSanté, invités à y participer, représentaient toutes les régions du pays. Durant l'atelier de deux jours, on s'est attardé à combiner les lignes directrices et les outils pour aider à la prise de décisions, à promouvoir les meilleures pratiques et à améliorer l'uniformité et l'efficacité de la prestation des services de TéléSanté. On a réuni l'information suivante sur chacun des six sujets au programme:

- Meilleures pratiques/lignes directrices - approches communes et réussites
- Leçons apprises - ce qui n'a pas marché et pourquoi
- Processus communs pour l'élaboration de politiques/lignes directrices
- Incidences pour une approche nationale
- Questions en suspens/Contraintes
- Mesures à prendre/Étapes suivantes

Le présent rapport donne un sommaire des recommendations formulées par les participants et participantes à l'atelier ayant trait au consentement aux services de TéléSanté; à l'inscription des patients, à la documentation et aux dossiers pertinents; aux descriptions de tâches, aux rôles et aux responsabilités; à la connaissance et à l'évaluation des services de TéléSanté; à la formation relative à TéléSanté; et aux questions d'interopérabilité. Le compte rendu au complet de l'atelier et un sommaire des mesures à prendre qui sont issues des recommendations sont présentés en annexe.

En plus des recommendations sur l'élaboration de lignes directrices concernant chacun des sujets, l'atelier national de 2002 des coordonnateurs et coordonnatrices de TéléSanté a permis d'en arriver à d'importantes constatations. Mentionnons la nécessité d'avoir plus d'information/de consultation dans les domaines prioritaires spécifiques; d'échanger plus d'information entre les programmes/projets de TéléSanté; de profiter davantage des possibilités de réseautage parmi les coordonnateurs et coordonnatrices de TéléSanté; d'avoir une 'voix' représentant les coordonnateurs et coordonnatrices de TéléSanté; et de définir clairement les voies à emprunter pour faire avancer les dossiers et les mesures à prendre. Pour maintenir l'activité et l'élan du groupe de coordonnateurs et coordonnatrices de TéléSanté, on a proposé les initiatives suivantes que l'on devrait considérer ou évaluer en fonction de leur valeur et de leur faisabilité :

- La création d'un groupe officiel de coordonnateurs et coordonnatrices de TéléSanté dans le cadre de la SCT
- La création de groupes d'intérêt spécial ou de travail
- L'utilisation d'un site Web et d'autres technologies pour faciliter le réseautage entre les coordonnateurs et les coordonnatrices
- La participation des coordonnateurs et coordonnatrices de TéléSanté dans les sous-groupes pertinents d'autres organisations professionnelles [c.-à-d. l'Association des infirmières et infirmiers du Canada (AIIC)]
- L'organisation d'ateliers de coordonnateurs et coordonnatrices de TéléSanté dans

l'avenir

Table of Contents

1	EXECUTIVE SUMMARY	3
2	INTRODUCTION AND OPENING REMARKS	3
3	INVITED SPEAKERS	5
4	CONSENT	5
5	REGISTRATION, DOCUMENTATION AND PATIENT RECORDS	8
6	JOB DESCRIPTIONS, ROLES AND RESPONSIBILITIES	9
7	TELEHEALTH AWARENESS AND EVALUATION	11
8	TRAINING	12
9	OTHER INTEROPERABILITY ISSUES	13
10	CONCLUSIONS	14
11	APPENDICES	16

1 Executive Summary

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In addition to the recommendations for guidelines in each of the subject areas, there were several key concluding messages arising from the 2002 National Telehealth Coordinators Workshop. These included the need for more information/input in specific priority areas; the need for more information exchange among telehealth programs/projects; the need for greater networking opportunities among Telehealth Coordinators; the need for a 'voice' representing the Telehealth Coordinators; and the need for some clear paths to escalate issues and action items. To maintain the activity and momentum of the Telehealth Coordinator group, the following initiatives were suggested and should be considered/evaluated for their merits and feasibility:

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2 Introduction and Opening Remarks

Chris-Anne Ingram, Chair, CST Education Committee and of the Workshop Planning Committee, opened the 2002 National Telehealth Coordinators Workshop by reviewing the background, purpose and planning process for the two-day event.

In October 2001, Health Canada and the Advisory Council on Health Infostructure (ACHI) sponsored a National Workshop for Telehealth Coordinators to facilitate the development of Canadian Telehealth Guidelines. During this one-day workshop, telehealth coordinators from across the country identified current operational practices and issues in the following areas:

- Quality videoconferencing and etiquette
- Consent, confidentiality, and videotaping of telehealth sessions
- Registration, documentation and patient records, and
- Job roles and responsibilities

A detailed report of the 2001 Workshop proceedings can be found in the document entitled "Developing Canadian Telehealth Guidelines - A National Workshop for Telehealth Coordinators" (available upon request).

The CST Education Committee subsequently received funding from Health Canada's Policy Research Program to support a follow-up workshop. This workshop entitled, "Developing Operational Standards, Skills and Core Competencies for Telehealth," was intended to further capture telehealth operational best practices and identify next steps towards the dissemination of practical experience and 'lesson learned' to telehealth practitioners across Canada.

A sub-committee of the CST Education Committee was established as the Workshop Planning Committee. Sixty Telehealth Coordinators, representing all regions of the country, were invited to participate. (Workshop Participant's List-Appendix A.)

As part of the workshop planning, a videoconference meeting was held in May 2002 with representatives from each province and territory. The objectives of this meeting were to review the outcomes of the 2001 Workshop, identify priorities and develop the agenda for the 2002 Workshop. Once the operational issues of greatest concern were identified, a preliminary agenda and a workshop format were created by the Workshop Planning Committee and in conjunction with the workshop facilitation, Dr. Sarah Muttitt. Twelve co-leads were identified at a national level to prepare background material on the selected topics. It was decided that this information would be presented at the workshop and serve as a foundation for the breakout discussions. Finally, participants at this videoconference meeting agreed that all the discussions held at the October 2002 Workshop would be captured in a final report that would be submitted to Health Canada, CST and more widely distributed to participants and other interested parties.

Dr. Sarah Muttitt, Director of TecKnowledge Professional Services, and lead facilitator for the 2002 National Coordinators Workshop, described the workshop objectives, format and ground rules (Workshop Agenda - Appendix B). The key objective was to **identify and support the development of operational guidelines to ensure that telehealth services are interoperable and optimally delivered and utilized across jurisdictions**. As there had been significant controversy over the term 'standard' versus 'guideline', it was emphasized that the goal was to provide guidelines - tools to assist in decision-making with the aim of promoting best practice and improving consistency and efficiency of telehealth service delivery. In each subject area, the following information would be collected:

- Best Practices/Guidelines - common approaches and successes
- Lessons Learned - what didn't work and why
- Common Process in Developing Policy/Guidelines
- Implications for a National Approach
- Outstanding Issues/Constraints
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The process for breakout sessions was described and full participation was encouraged. Thanks were extended to: Health Canada; the members of the Workshop Planning Committee; lead applicant, Dr. Jocelyne Picot; Atlantic Health Sciences Corporation for their administrative support; and to the guest speakers, co-leads, and co-facilitators.

Tina McKinnon, Chair, Telehealth Coordinator Workshop, October 2001, summarized the discussions and report from the Telehealth Coordinators Workshop held in October 2001.

Dr. Jocelyne Picot, provided an explanation about the document, Telehealth Projects/Programs in Canada. The Workshop Planning Committee in an effort to update available information and familiarize workshop participants with telehealth programs across the country, conducted a telehealth survey requesting participating Telehealth Coordinators to provide data on program funding, sites, network infrastructure, applications, staffing and physician reimbursement. The
results were compiled and distributed at the National Telehealth Coordinators Workshop. Dr. Picot, author of "The Telehealth Industry in Canada: Industry Profile and Capability Analysis" (Industry Canada, March 2000) and "Assessment of Videoconferencing in Telehealth in Canada" (Canadian Coordinating Office for Health Technology Assessment, May 2001), noted the remarkable growth in telehealth activity in Canada and the significant contribution that the telehealth coordinators have made towards this success. The Workshop Planning Committee will determine the next steps for analyzing, validating, and disseminating the information collected.

3 Invited Speakers

Over the past year, telehealth activity in Canada has grown exponentially, largely due to the availability of funding from the Canadian Health Infostructure Partnerships Program (CHIPP). Similarly, interest in the area of telehealth interoperability, policy and standards has also increased as evidenced by the number of standards initiatives currently underway. The Workshop Planning Committee felt it was critical to provide Telehealth Coordinators with an overview of these standard initiatives. Additionally, the committee felt it was imperative to include interested stakeholders from these initiatives to observe and participate in the workshop activity. This inclusion would increase the understanding between the various groups, avoid duplication where possible and identify potential synergies. Speakers representing three current standard initiatives were invited to the workshop to present background information /overview of their activity as it relates to the development of telehealth standards and guidelines in Canada.

Sandra Chatterton, Office of Health and Information Highway, Health Canada described the Canadian Health Infostructure Partnerships Program (CHIPP) as a two-year, $80 million, shared-cost incentive program, aimed at supporting collaboration, innovation, and renewal in health care delivery through the use of information and communication technologies (ICTs).

Valerie Hagerman, CST Policy and Standards Committee, provided a summary of the mandate of the Policy and Standards Committee as representing the CST as a national resource for policies and standards that will advance telehealth in Canada.

Dianne Parker-Taillon, noted that the National Initiative for Telehealth Guidelines (NIFTE) is an independent multi-stakeholder, 20-month project (January 2002-September 2003), that is funded by the Ivey Foundation.

Brenda Shestowsky, Office of Health and Information Highway, Health Canada, summarized the activities associated with Health Canada's CHIPP Interoperability & Standards Initiative. This project will try to determine the potential for interoperability for the CHIPP programs by getting a "snapshot" of variances and similarities relating to technical, clinical and administrative standards, and identify and analyze the gaps which could impede program implementation.

Dr. Harry Karlinsky and **Dr. Joanna Bates** put forth specific strategies to reduce the stress inherent in the role of the Telehealth Coordinator.

Summaries of the presentations from the guest speakers can be found in Appendix C.

4 Consent

There is a need to establish common guidelines for telehealth consent with a goal of reducing unnecessary duplication of process while at the same time ensuring full disclosure of relevant information to patients and compliance with existing federal, provincial and other legislation. To date, the majority

of telehealth programs have implemented a comprehensive written telehealth consent process, as documented at the 2001 National Telehealth Coordinators Workshop.

Despite this, there was great interest in revisiting the consent discussion since controversy remains over the need for written consent for a general telehealth encounter. Although most telehealth consent forms seek consent for the use of the telehealth technology versus treatment, consent legislation, as reviewed by co-leads, Mary Beth LeBlanc and Debora Robinson, refers specifically to medical treatment. This would imply that a general written consent form for telehealth would be unnecessary. Yet there are unique circumstances where a written consent form may not be necessary. Workshop participants attended one of two breakout sessions on Consent - the first to address the requirements for general telehealth consent and the second to identify consent requirements for other specific telehealth applications/activities.

The goals of the pre-workshop activities and workshop discussions on consent were the following:

- Collect a broad representation of consents used by telehealth programs across Canada
- Gather some background materials that reflect current stance on consent from CMPA, CNPA, legal counsel
- Provide overview of purpose and content of general telehealth consent
- Identify need for consent in special circumstances (videotaping, store-and-forward, promotional materials)
- Document process for developing consent 'policy' for a new site or program
- Identify issues for further action

A summary of the co-lead presentation on consent can be found in Appendix D and minutes from the breakout discussions in Appendix E. Sample Documents provided by the co-leads can be found in Appendix F.

The formal written telehealth consent process was implemented early on when projects and programs were in their infancy and considerable debate remained concerning the viability and feasibility of using telehealth technology for healthcare service delivery. It has become increasingly clear that the consent process itself has become a barrier to more widespread adoption and integration of telehealth into daily practice.

Legal and regulatory references indicate that consent is specific to treatment, whereas videoconferencing is simply the mechanism or tool for delivery. In addition, there is an argument supporting 'implied consent' by the presence of the patient at the telehealth consultation. Therefore, specific written consent for telehealth should not be necessary and the regular standing consent to treatment should suffice, supplemented with adequate information regarding the telehealth process. We have precedents to this opinion including Australia, where no specific telehealth consent is obtained, and the Province of Alberta, where efforts are being made to eliminate general telehealth consent and only retain consent for research, videotaping of clinical and educational sessions, and medical photography.

Eliminating formal written consent for telehealth does not lessen the need for full disclosure to the patient

regarding the telehealth process. This must include how the technologies work and what is involved in any specific application; potential risks and benefits; the choice to decline participation and alternatives available; contingency plans should the technology fail or be insufficient for clinical diagnosis/management; security, privacy and confidentiality; and information management and exchange. Additionally, a comprehensive quality assurance plan should be in place to ensure operational and technical excellence for all telehealth activities.

Although the majority of workshop participants accepted this recommendation to eliminate the written telehealth consent form, it was acknowledged that signed consent would still be required in specific circumstances including videotaping of clinical and educational sessions, patient photography, promotional/media events, collection of data for research or evaluation purposes, medical acts that would normally require consent, and possibly for some new applications. In many cases, consent forms already exist for these occurrences within specific facilities. Where possible, every effort should be made to integrate 'telehealth' consent with existing consent processes/documentation and moreover, create simple, multi-purpose consents to reduce duplication and confusion. If information is stored in a videotape, digital image or other format, policies must be established regarding storage, access and appropriate destruction of the materials. Consent for capturing and retaining these media should be stored in the patient record or with the materials themselves.

In summary, informed consent is more than just a signature on a form - it is a process of information exchange. Informed consent is a shorthand reference to the concept of informed decision-making or informed choice. The most important goal of informed consent is that the patient has an opportunity to be an informed participant in his or her healthcare decisions. There is little legal distinction between the efficacy or written, oral and implied consent although written consent is clearer proof that consent has been given. The workshop participants felt is that informed consent is required for all telehealth activities. This should be obtained at the client site, usually by the Telehealth Coordinator, and supported by an information sheet outlining the minimal information required to ensure the patient understands the risks, benefits, and other details of the telehealth process. Express, witnessed, written consent was not necessary for a general telehealth encounter, however, there was value perceived in the Telehealth Coordinator recording the delivery of the information to the patient on the patient record. Written consent is only required in specific circumstances including the videotaping of clinical or educational sessions, patient photography, promotional/media events, collection of data for research or evaluation purposes, medical acts that would normally require consent, and possibly for new applications.

Recommendations:

In order to move forward on the issue of consent, the following steps should be taken:

- **Eliminate written consent for general telehealth encounters**
- **Obtain written consent for videotaping of clinical or educational sessions, patient photography, promotional/media events, collection of data for research or evaluation purposes, medical acts that would normally require consent, and possibly for new applications**

- Until a national guideline for consent is established, telehealth programs must **continue to engage risk management teams and legal counsel** in the process of determining consent policy
- **Provide more education** to telehealth staff on the issues surrounding consent
- **Development of a position statement** on telehealth consent by the CST. Workshop recommendations should be shared with appropriate bodies, i.e. NIFTE, Health Canada, and CST Policy Committee to facilitate development of this position statement. This process would include:

    - Conducting broader review of literature and experience related to telehealth consent (including pending Alberta decision)
    - Incorporating other national and provincial regulations that impact consent policy including privacy and security legislation
    - Review of recommendations by national and provincial associations (Royal College of Physicians and Surgeons of Canada, Provincial Colleges of Physicians and Surgeons, Provincial Medical Associations, Canadian Medical Protective Association, Canadian Nurses Protective Association, etc.)
    - Ongoing participation of telehealth coordinators in decision-making process
- **Develop guidelines/template for information** that must be shared with patients and/or providers prior to telehealth session
- **Streamline consent process** for specific circumstances (videotaping of educational sessions, photography, etc.) and **integrate with pre-existing process/documentation** where possible.

5 Registration, Documentation and Patient Records

Consistent processes for patient registration, documentation and records for telehealth will assist in building operational interoperability across programs and jurisdictions. Commonly, telehealth processes have mirrored normal practice in order to allow smoother integration into the healthcare system. However, there is a need to identify and implement process improvements where appropriate to maximize efficiency. Similarly, it is critical to ensure sufficient information is captured and recorded to maintain a full and accurate patient record and support other healthcare tracking activities such as billing and workload measurement. Two breakout sessions were held to address Patient Registration, Documentation and Records - one to discuss the key issues around patient registration and the process for defining registration policy and a second to examine the processes related to telehealth documentation.

The goals of the pre-workshop activities and workshop discussions on Patient Registration, Documentation and Records were the following:

- Conduct a survey with a representative number of coordinators to identify what elements need to be addressed when trying to develop common registration, documentation and patient record policy and procedures between different

organizations and jurisdictions for telehealth activities

- Analyze the information, and determine what, if any, common approaches to each of the elements are employed. Issues and notable differences should be noted.
- Identify common approaches to patient registration, documentation and records
- Identify factors that determine or impact policy
- Describe process for developing policy for a new site or program
- Identify outstanding issues and solutions

A summary of the co-lead presentation by Liz Adair and James Coyle on Patient Registration, Documentation and Records can be found in Appendix D and minutes from the breakout discussions in Appendix E.

Although patient registration is acknowledged as necessary in all healthcare, and therefore, all telehealth encounters, there continues to be disparity in what constitutes patient registration and where it should occur for telehealth clients. The majority of workshop participants agree that patients should be registered where they are located (far end) unless the telehealth consultation is occurring at a non-health site. A minority of programs are registering patients at the consultant/clinician site only (near end) or both near and far end sites. Despite the fact that far end patient registration seems logical and appropriate, it compounds the issues surrounding physician licensure and credentialing for telehealth. If telehealth patients are registered at the far site only, and the service is therefore being delivered at the far site, physicians should be licensed and credentialed to deliver service at that site.

A similar debate exists about what documentation is required for a telehealth encounter and where the patient record should reside. Documentation of a telehealth session is required for the patient record, physician billing, hospital/healthcare funding, and workload measurement. Participants agreed that a complete record should reside at the patient site to ensure information availability and continuity of care. However, the pre-workshop survey results indicate that many programs have some or all of the patient information available at both the near and far end sites. Elements of information must exist at multiple sites due to a variety of regulatory requirements and constraints as well as the complex, multi-disciplinary nature of healthcare service delivery.

Standardized electronic health record deployment across Canada will resolve a great deal of the confusion surrounding patient documentation and registration. In the meantime, telehealth programs must largely mirror existing processes in order to avoid confusion, encourage 'buy-in' by clinical service providers, and facilitate easier integration with routine practice. Most telehealth coordinators play an important role in ensuring that proper documentation and registration procedures are followed and that the required information is captured correct and complete. By doing so, they facilitate effective telehealth service delivery, maintain the integrity of the health record, ensure continuity of care and allow the collection of supporting data to track utilization, billing, workload measurement and evaluation/QA.

Recommendations:

To develop a more standardized approach to patient registration, documentation and records, the

following should be considered:

- The majority of telehealth programs have instituted policies and procedures to support patient registration and documentation/record at the patient (far) site
- Identify opportunities to **work within existing processes, organizations, and initiatives** to find a common solution with the understanding that policy will be impacted by institutional, provincial and other related guidelines or legislation
- **Conduct a more comprehensive review of current practice** in Canada and other countries to support recommendations including additional analysis of collected data to determine reasoning behind registration and documentation policies and procedures

- **Further define patient registration**, particularly at near end (consultant/clinician) to assist in policy development
- **Identify a minimal data set** for various sites/applications to ensure sufficient information is captured and maintained
- **Promote the electronic health record** as an effective means of collecting, archiving and managing patient information related to telehealth
- The skills, backgrounds, and availability of telehealth coordinators will determine the extent of responsibility related to patient documentation
- **Raise awareness of other issues** related to patient registration and documentation including tracking utilization, billing, funding, workload measurement and resource planning

6 Job Descriptions, Roles and Responsibilities

The role of the telehealth coordinator is evolving in response to maturity of the telehealth field, and the challenges and complexities inherent in this new role. As a result, new skills and competencies are required. The term, 'Homo Telehealthus', was coined by co-leads Cathy Holmes and Stephanie Froissart, to describe the multi-functional role that is required to ensure the operational success of any telehealth program.

The workshop participants were given an option to attend one of two breakout sessions related to Job Descriptions, Roles and Responsibilities. The first breakout group identified the roles and responsibilities of Telehealth Coordinators and support staff while the second session examined human resource challenges.

The goals of the pre-workshop activities and workshop discussions on Job Descriptions, Roles and Responsibilities were the following:

- Collect a broad representation of job descriptions and organizational charts from telehealth programs across Canada
- Identify critical functions for successful operational telehealth
- Identify human resource issues for telehealth coordinators and strategies to manage

A summary of the co-lead presentation on Job Descriptions, Roles and Responsibilities can be found in Appendix D and minutes from the breakout discussions in Appendix E. Additional documents

provided by the co-leads can be found in Appendix F.

The position of a Telehealth Coordinator is a multi-functional role. Although there is no single job description, it is important that candidates possess certain core competencies and skills (as outlined in the minutes in Appendix E) to ensure job success. It is equally important that we acknowledge and 'embrace' the differences between the individuals in this role. The Telehealth Coordinator position requires supporting roles to fulfill all the necessary functions for successful operational telehealth. The leadership/management role should be captured in the language describing the Telehealth Coordinator to ensure appropriate recognition and remuneration. The actual title of Telehealth Coordinator, however, should not be standardized as it will not uniformly fit into all organizational structures and the position will evolve and become more fully integrated into the healthcare system. At that time, the functions currently performed by Telehealth Coordinators will still be required but are more likely to be distributed amongst existing healthcare, administrative and Information Technology (IT) staff.

Certification and/or accreditation is an option for providing credibility to Telehealth Coordinators. This would ensure that candidates in this position have the necessary knowledge and skill set necessary for the role. There was no consensus on this subject and a number of arguments for and against were raised. In general there appears to be more support for other alternatives such as earlier exposure to telehealth during career training, orientation program, networking with peers, 'communities of learning', investment in professional development, and flexibility in hiring practices to counter healthcare staff shortages.

The key human resource challenges are recruitment and retention of telehealth staff, stress and burnout of Telehealth Coordinators, and professional development to meet the broad and evolving needs of the role. A number of strategies and 'best practices' to address these issues are captured in the minutes and the Job Descriptions Survey - Strategies document found in Appendix F. Generally, the Telehealth Coordinator role can be made richer and less stressful with the following approaches:

- Clear definition of role and accountability
- Solid commitment and support from management and/or funding bodies - institutional, regional, government or other - including appointment of dedicated telehealth staff, the incorporation of telehealth into larger strategic plans, and sustainability funding
- Centralized telehealth program management including strong supporting and back-up personnel to address/control full range of day-to-day operational issues
- Sufficient investment in training and professional development of telehealth team
- An effective communications strategy to raise telehealth awareness and appreciation in facilities, communities, health regions and beyond
- Mentoring, peer support and collaboration with other coordinators

Recommendations:

In order to further evolve and sustain telehealth personnel, the following is recommended:

- Job descriptions, roles and responsibilities be considered a **high priority** area with a focus on competencies rather than standardized job descriptions
- **Further define and detail the core competencies** for Telehealth Coordinators and

supporting staff (the Telehealth Coordinators should take a leading role in this activity with assistance from Human Resource experts as necessary)

- Perform a **formal task analysis** for Telehealth Coordinators and supporting roles (potential funding from HRDC)
- **Determine how telehealth positions may best fit into institutional human resource frameworks** (performance appraisals, job review process, pay scales, etc.)
- Recognizing the broad range of skills required by Telehealth Coordinators, **identify priorities for professional development**
- In preparation for the future, **telehealth should be integrated with other e-health job descriptions and a broader range of skills developed**
- Promote opportunities for Telehealth Coordinators to **share knowledge, lessons learned and tips** with other coordinators across the country
- Develop a formalized **network of peers** to provide information and support using technology to facilitate where possible (websites, email, chat rooms)
- **Assess the risks and benefits of an accreditation or certification program** for Telehealth Coordinators

7 Telehealth Awareness and Evaluation

Telehealth Coordinators are commonly involved in promotion and evaluation activities for their programs. Promotion is key to facilitating the adoption of telehealth and increasing network utilization. Evaluation often becomes part of the message to be shared in telehealth promotion and is critical to securing ongoing support from government and other funding bodies for sustaining, growing and improving telehealth service delivery. Identifying common requirements and successful strategies for telehealth promotion and evaluation will allow these tools to be shared across programs, providing greater consistency to approach, and minimizing additional time and effort to implement. A breakout session was held for Telehealth Awareness to discuss issues and communications strategies to promote telehealth awareness and knowledge sharing. A second breakout session was held for Telehealth Evaluation to examine the critical issues and approaches for telehealth research and evaluation.

The goals of the pre-workshop activities and workshop discussions on Telehealth Awareness and Evaluation were the following:

- Collect promotional materials, brochures, newsletters and communications strategies from a representative number of coordinators across Canada
- Document guidelines and best practices for promoting and evaluating telehealth

A summary of the co-lead presentation by Carol Fenton and Wendy Barker on Telehealth Promotion can be found in Appendix D and minutes from the breakout discussions in Appendix E.

There is a consensus that the ongoing promotion and evaluation of telehealth is essential to more widespread adoption and integration of telehealth into healthcare service delivery. A communications plan that captures the key messages to be delivered, the multiple stakeholders or audiences to be

targeted, and the most appropriate media to be used should guide promotional activities. Unfortunately, the money and expertise for developing and delivering a communications strategy is often not available for telehealth projects/programs. Support for telehealth promotion at a higher level (medical/nursing schools, national professional bodies, provincial/territorial ministries, funding agencies, Health Canada, and other) would be beneficial. For the CHIPP projects, a communications plan was required at the time of proposal submission. Health Canada - OHIH is currently reviewing these plans and activities in order to incorporate them into a broader dissemination strategy for CHIPP results.

Similarly, though evidence-based evaluation of telehealth is required, many projects and programs are under-funded and neither the money nor the expertise is available to support comprehensive, quality evaluation. Evaluation must be stakeholder driven and tied to the goals and objectives of the telehealth project/program. Evaluation tools and design must be valid, reliable, and pre-tested where possible. In addition, telehealth evaluation should be consistent with national standards and guidelines such as the Canadian Evaluation Society Guidelines and the Institute of Medicine Guidelines. Evaluation tools should be similar across projects to allow comparative and collective analysis of results. Evaluation also requires a communication/dissemination plan.

Recommendations:

Recommendations for telehealth awareness and evaluation are as follows:

- Develop a **standardized process for evaluation** so that data may be aggregated with other jurisdictions resulting in greater power and validity of results
- **Set aside the necessary resources**, both money and expertise, to ensure effective telehealth promotion and evaluation
- **Develop and integrate communications and evaluation plans at the start of a project**
- **Continue evaluation beyond pilot phase** to ensure ongoing analysis of outcomes, cost effectiveness and quality improvement to support future sustainability and growth of telehealth programs
- **Design communications and evaluation plans with the purpose, the audience, and 'best practices' in mind**
- **Common evaluation indicators, tools and frameworks should be identified and made available** to new telehealth projects and programs
- **Develop a database of successful promotional and evaluation tools** accessible via the web
- Telehealth programs must **share their knowledge and experience** with telehealth promotion and evaluation

8 Training

Telehealth training typically involves multiple audiences, a variety of types and methods of training, and different supporting tools and/or documentation. It is complex and time-consuming to develop, implement and maintain an effective training program that meets the unique needs of the telehealth

setting. By identifying training requirements, best practices and optimal methodologies, there is an opportunity to develop a common tool kit, potentially accessible via the CST or other website, that could be customized across different programs and applications. This could potentially improve the consistency of training delivery and the skills developed in telehealth staff and end-users. Successful telehealth training programs will continue to require dedicated training positions, sufficient funding and time for program development, as identified by co-leads, Angela Nickoloff and Audrey Huziak.

Two separate breakout sessions were held to address the training of telehealth coordinators and the training of other telehealth staff.

The goals of the pre-workshop activities and workshop discussions on Training were the following:

- Collect a broad representation of training approaches from telehealth coordinators across the country
- Identify best practices for training coordinators, technicians, support staff and end users

A summary of the co-lead presentation on Telehealth Training can be found in Appendix D. Minutes from the breakout discussions are in Appendix E.

Training telehealth coordinators, support staff and end-users is a significant and complex activity for telehealth programs. It is important that telehealth training is specific, relevant, timely and ongoing to meet the needs of multiple and changing telehealth team members. Background, skills, and job expectations will determine the training needs of individual staff and there ideally audience. Training should be delivered by skilled trainers and supported by appropriate tools and reference manuals to ensure consistent and comprehensive learning. There is consensus that telehealth training should not be comprised of 'technical' training alone. It should also include elements of clinical and operational Telehealth. Similar to comments made for telehealth promotion and evaluation, there is frequently not enough dollars, time or expertise available to ensure an effective telehealth training program is properly implemented.

Although the possibility of a formal, accredited Telehealth Coordinator training program affiliated with an educational institution was suggested, this was not a high priority for the majority of the Telehealth Coordinators present at this workshop. Because of the broad, multi-functional nature of the role and the variety of backgrounds and skill sets among coordinators, a more flexible, self-directed approach to training and professional development seems preferable at this time.

Recommendations:

Recommendations for telehealth training are as follows:

- **Ensure there are sufficient funds, time and expertise** allotted to training
- **Develop a consensus on minimal data set/core competencies** necessary for each telehealth team member and end-user to guide training content
- **Develop or access skills in technical training, procedural/process training, and clinical training** for non-health workers
- **Ensure flexibility in content and delivery** to ensure that all audience needs will be

met. A modular approach was suggested as a method of providing comprehensive content while allowing participants to pick and choose the relevant, 'just-in-time' content required. **Beware of the cookie cutter approach !!**

- Provide access to **training courses outside telehealth** to support development of other required skills (e.g. Business management, project management, Train-the-trainer, etc.)
- **Develop and regularly update training manuals, quick reference guides and other tools** to act as reference for telehealth staff and end-users
- **Engage the vendor community** to work with the telehealth team in developing and delivering appropriate training that meet the specific needs of telehealth
- Provide opportunities for telehealth programs to **share successful training strategies and collaborate on developing new and innovative training programs** (e.g. develop a telehealth training toolbox (clearing house) on the web so that coordinators (sub-group) could evaluate documents to put in toolbox and provide access to members)
- **Ensure training is offered frequently and regularly** to address staff turnover and to promote optimal telehealth utilization

9 Other Interoperability Issues

Despite the lack of national telehealth guidelines, there is a significant amount of cross-jurisdictional telehealth activity underway in Canada. The workshop held a breakout session to discuss the key issues that are barriers to telehealth across provincial borders, governing agencies and ministries. This provided the opportunity to share successful approaches and identify collective strategies to move government and other agencies to effect the necessary policy changes to facilitate cross-jurisdictional telehealth.

In this session on Other Interoperability Issues, the goals of the pre-workshop activities and workshop discussions were the following:

- Identify programs that are actively involved in cross-jurisdictional activities
- List and prioritize issues from these programs
- Gather examples of policies and approaches that address cross-jurisdictional issues
- Identify key operational issues to be addressed when conducting cross-jurisdictional telehealth activities
- Determine a common approach and process for establishing cross-jurisdictional policies in the absence of national standards

A summary of the co-lead presentation on this topic delivered by Doreen Tennant and Tina McKinnon can be found in Appendix D. Minutes from the breakout discussions are in Appendix E.

Telehealth adoption into mainstream practice and longer-term sustainability remain somewhat precarious in the face of a number of outstanding issues related to physician licensure, credentialing, and

reimbursement policies. Success to date has had to happen, in no small way, on the creative efforts and determination of telehealth pioneers and champions to 'make it work'.

Participants described current processes as 'survival tactics'! Although there are no national standards or guidelines in place as yet, there are successful precedents and initiatives inside and outside Canada as outlined in the minutes of this session. Pressure is required from many jurisdictions and disciplines to focus the attention necessary to resolve these issues and remove remaining barriers to telehealth.

Recommendations:

Opportunities identified to resolve cross-jurisdictional issues include the following:

- Telehealth Coordinators to **educate and engage professional associations, policy and standards organizations, and other groups** to ensure that consistent and constant pressure is placed on government to address the issues
- **Develop a position paper on cross-jurisdictional issues for government** - this may be a task for the CST Policy Committee or Board or could be assigned to appropriate subject experts
- As CHIPP has been designed for and in turn supports and funds cross-jurisdictional telehealth and Electronic Health Record (E H R) activities, **Health Canada can play a role in working with telehealth experts and policy groups to resolve outstanding issues**
- The Canada Health Act ensures equal access to healthcare for all Canadian citizens and telehealth is one solution for providing equal access. **The government can be pressured to resolve the cross-jurisdictional barriers to telehealth in order to fulfill the tenants of the CHA**
- The optimal solutions would include national licensure for physicians, simplified credentialing procedures, and unrestricted telehealth reimbursement for fee-for service physicians. Until such solutions are in place, **simple, consistent and replicable processes should be instituted** wherever possible
- **Liaise with other groups** (e.g. provincial health care billing plans, the Advisory Committee on Information and Emerging Technologies, etc.) that may be able to assist in moving the cross-jurisdictional interoperability agenda forward
- **Capture an inventory of interoperability issues, successful strategies, templates for contracts and agreements, and other relevant information** to advance our understanding of cross-jurisdictional issues and solutions

10 Conclusions

In addition to the recommendations for guidelines in each of the subject areas, there were several key messages from the 2002 Telehealth Coordinators Workshop. These included the need for: more information/input in some areas; more information exchange among telehealth programs/projects; greater networking opportunities among Telehealth Coordinators; a 'voice' representing the Telehealth Coordinators; and the need for some clear processes/ paths to escalate issues and action items. The

workshop served as a catalyst for a great deal of activity from the participants. This included the collection and presentation of data on pertinent topics by the co-leads, the enthusiastic breakout discussions, and the outputs generated by the larger group. To maintain the momentum of the Telehealth Coordinator group, the following initiatives were suggested and should be considered/evaluated for their merits and feasibility:

1. The development of a formal Telehealth Coordinators group within CST

The Telehealth Coordinators represent a critical piece of the telehealth infrastructure in Canada including unique skills, knowledge, and front-line experience. This intellectual property should be captured, shared, and managed. This requires a supporting infrastructure and a vehicle to represent, coordinate, and prioritize activities. The Canadian Society of Telehealth was viewed as a logical choice to house the Telehealth Coordinators group. Other options may include professional organizations (nursing, medical, IT), educational institutions (through a certification/accreditation program), or industry and/or government sponsorship.

2. Creation of Special Interest or Working Groups

Many outstanding issues and information gaps exist in the area of telehealth guidelines and best practices. In many cases, the implementation of Special Interest or Working Groups to address specific issues and tasks could move the agenda forward more quickly and effectively. Examples are found in the recommendations for each subject area. By concentrating the efforts, there is greater likelihood of concise, relevant, and timely guidelines being established in each of the areas, as well as a more effective tactical plan being developed in order to promote implementation.

3. Website and other technologies to facilitate networking between Coordinators

Information sharing, mentoring, and peer support are essential for promoting telehealth best practices, operational interoperability, and job satisfaction for Telehealth Coordinators. Establishing a safe, secure website for networking, support, information exchange, collaborative research, database access, and professional development is a high priority for Telehealth Coordinators.

4. Participation of Telehealth Coordinators in relevant subgroups of other professional organizations

Encouraging the participation of Telehealth Coordinators in relevant professional organizations will raise the awareness of telehealth and promote integration of telehealth into mainstream healthcare service delivery.

5. Future Telehealth Coordinator Workshops

The Telehealth Coordinators are already stressed and stretched to meet expectations in their role. To find additional time and energy for working groups to address guidelines and other focused Coordinator activities may be unrealistic. Nevertheless, there is a need to continue the networking and dialogue established at the 2001-2002 Coordinator Workshops. Financial resources and institutional commitment for Telehealth Coordinators are required to support these worthwhile endeavors if this valuable work is to continue.

11 Appendices

Appendix A - Workshop Participants

Appendix B - Workshop Agenda

Appendix C - Invited Speaker Presentations

Appendix D - Co-Lead Presentations

Appendix E - Minutes from Breakout Group Discussions

Appendix F1 - Job Description Survey - Strategies

Appendix F2 - Profile of Canadian Homo Telehealthus

Appendix F3 - Sample Consent

Appendix G - Summary of Action Items from Recommendations

Appendix H - Workshop Evaluation Summary

Health Policy Research Program Project Number:

6795-15-2001/4430009

National Telehealth Coordinators Workshop 2002

Appendices to Final Report

October 1-2, 2002
Sheraton Wall Centre
Vancouver, British Columbia

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Table of Contents

APPENDIX A - WORKSHOP PARTICIPANTS	2
APPENDIX B - WORKSHOP AGENDA	5
APPENDIX C - INVITED SPEAKERS PRESENTATIONS	8
APPENDIX D - CO-LEAD PRESENTATION SUMMARIES	17
APPENDIX E - MINUTES FROM BREAKOUT DISCUSSIONS	23
APPENDIX F1 - JOB DESCRIPTION SURVEY - STRATEGIES	50
APPENDIX F2 - PROFILE OF CANADIAN 'HOMO TELEHEALTHUS'	52
APPENDIX F3 - SAMPLE CONSENT	55
APPENDIX G - SUMMARY OF ACTION ITEMS FROM RECOMMENDATIONS	68
APPENDIX H - WORKSHOP EVALUATION SUMMARY	71

APPENDIX A - WORKSHOP PARTICIPANTS

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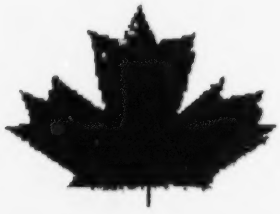
APPENDIX B - WORKSHOP AGENDA

National Telehealth Coordinators Workshop
Tuesday, October 01, 2002

Time	Topic
0815 - 0845	Registration
0845 - 0900	Welcome and Opening Remarks Chris-Anne Ingram, Chair Education Committee, CST Sandra Chatterton, OHIH, Health Canada
0900 - 0915	Sarah Muttitt # Introduction # Workshop Objectives # Review of agenda and process
0915 - 0930	Reports # Review of 2001 Coordinator Workshop - Tina McKinnon # National Survey - Dr. Jocelyne Picot
0930 - 1015 # 10 mins each # Q&A	Current Standards Initiatives # CST Policy Committee - Valerie Hagerman # NIFTE - Dianne Parker-Taillon # CHIPP Interoperability - Brenda Shestowsky
1015 - 1030	Break
10:30 - 12:00 6x15 mins	Presentations from Subject Leads
1200 - 1300	Lunch
1300 - 1430 Concurrent sessions	Breakout 1) Consent a) Telehealth Consent & process to develop policy b) Other consents - videotaping, S&F, promotional 2) Registration, Documentation & Patient Records a) Patient Registration b) Patient Documentation & Records - including images
1430 - 1445	Break
1445 - 1600	Group Presentation & Discussion Assignment of Follow-up Action Items
1600 - 1630	Sarah Muttitt Summary & Prep for following day



National Telehealth Coordinators Workshop
Wednesday, October 02, 2002

Time	Topic
0830 - 0845	Sarah Muttitt # Review of Day 1 # Agenda for Day 2
0845 - 0915	Dr. Harry Karlinsky and Dr. Joanna Bates
0915 - 1030 Concurrent Sessions	Breakouts 1) Job Descriptions, Roles & Responsibilities a) Critical Functions & changing role b) Recruitment & retention; job satisfaction, burnout, workload measurement 2) Telehealth Awareness and Evaluation a) Promotion, change management, networking, lessons learned b) Evaluation, QI, Research
1030 - 1045	Break
1045 - 1200	Group Presentation & Discussion Assignment of Follow-Up Action Items
1200 - 1300	Lunch
1300 - 1430 Concurrent Session	Breakouts 1) Training a) Telehealth Coordinator b) Other Support Staff 2) Other interoperability a) Cross-jurisdictional operational considerations b) Process for developing cross-jurisdictional activities
1430 - 1445	Break
1445 - 1600	Group Presentation & Discussion Assignment of Follow-up Action Items
1600 - 1630	Sarah Muttitt Summary Next Steps Acknowledgements Evaluation

Appendix C - Invited Speakers Presentations

Appendix C - Invited Speakers' Presentations

Sandra Chatterton - OHIH - Health Canada

The *Canadian Health Infostructure Partnerships Program* (CHIPP) is a two-year, $80 million, shared-cost incentive program, aimed at supporting collaboration, innovation, and renewal in health care delivery through the use of information and communication technologies (ICTs). There are currently 29 CHIPP-funded model implementation projects across Canada focusing on two strategic areas: telehealth and electronic health records (EHR). The selected projects were patient centered, strategically focused, and demonstrated collaboration amongst provinces and different jurisdictions. The types of projects funded were:

- Telehealth/EHR - 6 projects - 20%
- E-HR (Electronic Health Record) - 8 projects - 28%
- Telehealth - 15 projects - 52%

OHIH leads a number of project oversight activities including project management, evaluation, sustainability, privacy and confidentiality and standards/interoperability.
Examples of CHIPP funded projects include:

- Health Infostructure Atlantic: Total cost of $25M (CHIPP funded $12M); working in collaboration between four Atlantic provinces with three key initiatives - Tele-i4 (teleradiology across the four provinces), Common Client Registry and Case Management
- North Network: telehealth network providing remote consultations and education to 60+ sites in Ontario with links to Winnipeg, First Nations Communities and other
- BC Telehealth: multi-disciplinary, province-wide telehealth network providing services in Emergency/Trauma/Continuing Education, Maternal Child Health and Pediatric Palliative Care

Tina McKinnon - Manager, Telehealth Services, Nunavut

Tina McKinnon summarized the discussions from the Telehealth Coordinators Workshop held in October 2001.

- Videoconferencing etiquette
  - Discussion and consensus on guidelines and best practices for quality videoconferencing in the healthcare setting
- Consents, confidentiality and videotaping sessions
  - Agreement on the need for informed, written consent for use of the telehealth technology (vs consent for treatment)
  - Consent to be obtained by the telehealth coordinator prior to any telehealth session, accompanied by a consistent, comprehensive information package, and filed as part of the patient record
  - Specific consent required for videotaping of telehealth sessions
  - Review of operational processes to ensure confidentiality and privacy of teleheath encounters

- Registration, documentation and patient records
    - Telehealth policy and procedures ideally built on existing processes and reflecting facility/regional/provincial standards
- Job roles and responsibilities
    - Identification of common functions that need to take place for telehealth to occur

A detailed report of the 2001 Workshop proceedings can be found in the document entitled "Developing Canadian Telehealth Guidelines - A National Workshop for Telehealth Coordinators" (available upon request).

Dr. Jocelyne Picot - President, Infotelmed Communications Inc.

In an effort to update available information and familiarize workshop participants with telehealth programs across the country, a telehealth survey was conducted by the Workshop Planning Committee. Telehealth Coordinators provided data on program funding, sites, network infrastructure, applications, staffing and physician reimbursement. The results were compiled and distributed at the National Telehealth Coordinators Workshop. Dr. Picot presented an overview of the survey process and results.

In 1996, Dr. Picot and colleagues began counting telehealth projects for a first Industry Canada report. Even by including everything in health that used communications technologies, the authors were only able to compile a very short list of projects - and only one or two were established programs. A later report in 2000 confirmed considerably more activity with a total of 40 projects assessed (Picot, Jocelyne and Cradduck, Trevor. The Telehealth Industry Canada: Industry Profile and Capability Analysis: March 2000. Life Sciences Branch, Industry Canada). Another study completed for CCOHTA in 2001 identified 250 telehealth videoconferencing sites across Canada (Noorani, Hussein and Picot, Jocelyne. Assessment of Videoconferencing in Telehealth in Canada: May 2001. CCOHTA, Ottawa).

There are many groups currently counting and classifying telehealth, telemedicine and e-health projects. But the telehealth survey completed for this year's Telehealth Coordinator Workshop is far more impressive - and after you take stock, realizing the phenomenal growth in telehealth activity across the country, it's tempting to stop there and look at the number of projects as an accomplishment. Yes, we are counting them - but is this all there is to it? Or should we be counting research and publications or innovation and technological change? Or the number of Canadian companies or the size of the industry - the vendors, the size of the eventual market, the prospects, the investors, etc.? And what would we have learned after all that counting? Indeed, what have we learned over the last 6 years of implementing pilots, experiments and projects?

What's new here? Does a large number of small projects amount to a new way of delivering health care in this country? If you compare what is being spent on telehealth to what is being spent on the total health care industry, both private and public, in this country, it is a very small amount. For this reason,

perhaps it isn't surprising that so few people know e-health and telehealth exist.

So what difference do all these projects, activities and programs make? First, these projects could not happen without the collaboration of many players. And therein lies a potential other list - the telehealth partners! Moreover, this collection amounts to about 1000 sites across the country being serviced by fewer than 250 (usually) part time employees or professionals (excluding physicians). So, one part time person is serving patients and professionals at four or more sites spread across what are sometimes very large territories on the basis of a 24/7 time frame. Few service industries let alone health care systems can make a claim like this. And the whole thing is being managed by a group of tireless individuals - the Telehealth Coordinators - without recognized credentials, extra pay or additional perks.

What is the real impact of these projects on patients and professionals - the real users? If you can answer that question, you know the meaning of access to quality care and you are no longer counting projects, employees, sites, applications, funds, you are in the business of evaluation - trying to assess the real benefit to the health of Canadians no matter where they are.

So then, the next question has to be - how come no one - or practically no one - knows about it? How do we bring this industry to the attention of the public and the world at large. It may be by counting projects and studies and drop sites and FTEs but it likely will require something more dramatic. Our goal must be to demonstrate the impact of the whole effort on the many Canadians being served by telehealth.

Dr. Picot closed by posing two final questions to be considered over the course of the workshop. What is the real impact of telehealth on the health of Canadians? And how can we tie together all of this fragmented effort into one cohesive picture which tells the story as completely and holistically as possible?

Valerie Hagerman - CST Policy and Standards Committee

The mandate of the Policy and Standards Committee is to represent the CST as a national resource for policies and standards that will advance telehealth in Canada. This Committee does not have the mandate to develop telehealth policies and standards. The duties and operational guidelines of the CST-PSC include:

- To identify significant needs/gaps in telehealth policy which affect the widespread diffusion of telehealth in Canada.
- To recommend, in conjunction with other organizations, strategies and actions to those responsible for implementing policies and standards (i.e. Ministers of Health, licensing authorities, professional colleges and associations, standards organizations and other stakeholders).
- To advocate for changes in policies and standards that are a deterrent to the advancement of telehealth.
- To increase awareness between stakeholders regarding telehealth policies.

- To communicate best practices.
- To foster an environment conducive to the development of interoperable telehealth policies and standards.

The CST-PSC focus, therefore, is on needs assessment, advocacy and communication. Advocacy can be a key area for impact. The SCT-PSC advocates for changes in policy that present barriers to the diffusion of telehealth knowledge and the development of policy that will foster the integration of telehealth into the healthcare system in Canada. The committee will endeavor to foster an environment in which individuals and groups can collaborate and converge their resources and talents to help affect needed change. Alliances with other organizations can build strength in making recommendations to government, national bodies and other stakeholders, to develop or change policies.

The members of the CST-PSC are Wayne Bell, Chair, Valerie Hagerman, Carl Robbins, Raymond Pong and Patricia McLean. This team has varied and vast experience in the telehealth field and has linkages to other organizations which can benefit the work of this Committee. Some of the linkages include:

- Wayne Bell, NIFTE Advisory/Steering Committees, CHIPP Interoperability and Strategy Advisory Committee, International Bar Association, International CST Committee.
- Valerie Hagerman, CHA representative on NIFTE Advisory Committee, CST Education Committee.
- Carl Robbins, EHR/Telehealth Working Group, Co-Chair.
- Raymond Pong, Research Team Coordinator and member of the Steering Committee, NIFTE.
- Patricia McLean, Executive Director, Canadian Nurses Protective Society.

The priorities of the CST-PSC for 2002-2003 are to:

- Increase awareness of the CST-PSC (how CST members can access and use this committee in their work environments).
- Finalize a workplan that identifies and prioritizes specific activities and deliverables.
- Expand membership to increase linkages with other national standards/policy setting organizations.
- Leverage CST web site as a communication and advocacy tool.

The participants of the Telehealth Coordinators Workshop were encouraged to refer issues that arise from the workshop regarding policy, standards to CST-PSC for further review and analysis. That Committee in turn will refer the issues to the most appropriate national group.

Dianne Parker-Taillon - NIFTE

The National Initiative for Telehealth Guidelines (NIFTE) is an independent multi-stakeholder, 20 month project (January 2002 - September 2003), funded by the Ivey Foundation. The goals of the Project are:

- To develop the framework of national guidelines
- To develop a national, interdisciplinary stakeholder group

- To develop a sustainable network to facilitate ongoing integrated multi-sectoral collaboration.

The primary outcome of the project will be a framework of national guidelines for regulated health professionals in developing their specific standards, for telehealth provider organizations as a benchmark for standards for service provision and for the Canadian Council on Health Services Accreditation (CCHSA) to assist in developing accreditation standards. The scope of the Project includes:

- Teleconsultation
- Teletriage
- Telecare
- Telepharmacy
- Clinical decision support tools
- Telementoring
- Technology and equipment requirements

The Project scope does not include tele-education, public education, professional education and telemedicine in space.

NIFTE is interested in the development of guidelines for telehealth service provision and the degree of regulation required in offering that service. Guidelines imply following recommendations and to some extent flexible practices. Guidelines are used voluntarily and generally refer to issues that are qualitative, rather than quantitative as in the case of standards. Standards are rigid and have defined criteria. (Loane and Wooton, Journal of Telemedicine and Telecare 2002:863-71). The common purpose to both is that they are instituted to improve consistency and outcomes. They promote best practice and assist with decision making.

Telehealth is still in the phase of using guidelines as it takes a long period of time in a given field to develop standards, which are based on extensive knowledge and defined criteria. Telehealth is still likely to evolve and change and therefore the flexibility of guidelines is practical at this point.

The activities of NIFTE:

1. National interdisciplinary stakeholder network
2. Environmental Scan
3. Framework of national guidelines
4. Telehealth Information to CCHSA
5. Database of key stakeholders
6. Communication/dissemination of information

The Environmental Scan involves:

- Organizational context
    - Organizational readiness
    - Quality assurance measures

    - Accountability
    - Continuity (i.e. how telehealth is linked and coordinated with other services)
- Human resources
    - Roles and responsibilities
    - Licensure
    - Liability
    - Reimbursement
    - Competency, education and training
- Clinical standards/Outcomes
    - Communication with clients/patients
    - Standards/quality of care
    - Clinical outcomes
    - Patient confidentiality and information security
    - Informed consent
    - Duty of care
    - Ownership of records
- Technology and equipment
    - Security
    - Image validity/efficacy/effectiveness
    - Safety
    - Acceptability
    - Interoperability
    - Reliability
    - Scalability

Much of the work NIFTE is involved with is a parallel to the efforts of the Telehealth Coordinators group and the two groups should work more closely and collaborate. NIFTE can assist the Coordinators in their efforts to have national guidelines in place.

Timelines for the NIFTE Project are as follows:

Phase 1, Project Start-up — October-December 2001

Phase 2, Instrument development — January-May 2002

Phase 3, Investigation and data gathering — June-December 2002

This is the present phase, which involves surveys of telehealth programs/projects and other stakeholders, literature reviews and key informant interviews.

Phase 4, Framework development/consultation January -June 2003

Phase 5, Project consolidation and wrap-up — July-September 2003

The Project will not seek formal approval of all recommendations by regulating authorities or formal development of standards and accreditation guidelines.

Brenda Shestowsky - OHIH - Health Canada

CHIPP projects are interoperable in and of themselves given the nature and requirements for funding (multidisciplinary, cross-jurisdictional) but unfortunately they often function as islands. The impact of CHIPP requires attention and study. For example, now that the technology is moving from ISDN to the IP world, how does this affect interoperability between projects, given that some projects may never move to IP? Coordinators are encouraged to develop policies, procedures and protocols for their individual projects as a part of CHIPP, but how does this activity affect the overall goal to develop national standards?

Health Canada will try to determine the potential for interoperability for the CHIPP programs by getting a "snapshot" of variances and similarities relating to technical, clinical and administrative standards. Identification and analysis of the gaps, which could impede program implementation, is also a goal.

The CHIPP Interoperability strategy includes:

- Project Oversight
    - Project Management (Financial accountability and Reporting, Risk Management)
    - Evaluation
    - Sustainability
    - Privacy and Confidentiality
    - Standards and Interoperability
- Liaison activities (A report on the Canadian telehealth infrastructure will be available at the end of this year)
- CHIPP Standards and Interoperability Advisory Committee
    - Involvement of CIHI, Canarie, Industry Canada, CST, CHIPP funded projects and other national ICT projects.
    - Survey and report
      . Surveys taking place from April - August 2002 (Data analysis completed in October, 2002)
      . Surveys include telehealth and EHR (issues and standards for archiving data vs. real time data)
      . Analysis in progress

The CHIPP surveys will identify:

- Emerging standards and interoperability issues
- Tools and processes (e.g. templates, training manuals)
- Next steps for standards and interoperability

The early results from the surveys indicate the following:

Technical

- Predominant Physical Infrastructure is a private or dedicated WAN
- Predominant network protocol is TCP/IP

- Hardware based firewalls are most common
- 2 major vendors are Tandberg and Adcom/Polycom

Administrative

- Majority not using automated scheduling systems (3 programs are testing automated scheduling)
- Majority log session information
- Most conduct audits and report unusual activities
- Most have or are developing policy and procedure manuals

Clinical and Policy

- Clinical applications
  - Majority are Radiology (PACS)
  - Others include ER triage, OBS, Dermatology, Orthopedics, Psychiatry and Rehab

- Reimbursement
  - Many physicians are salaried or receive payment from the program

- Licensure
  - Some programs have an MOU in place for cross border practice
  - Many have no resolution and continue to use physicians in their own regions

- Privacy
  - Many consider privacy to be a huge undertaking
  - Many equate privacy and confidentiality with network security
  - Further analysis (survey) is required on privacy to get to specific issues.

The next steps include:

- October 2002
  - Complete data analysis
  - Complete summary analysis of provincial, territorial and national networks

- November 2002
  - Listing of available tools (MOU templates, manuals, etc.)

- December 2002
  - Publish report (will be available on the OHIH web site)

Dr. Harry Karlinsky and Dr. Joanna Bates - University of British Columbia

Two roles of the telehealth coordinator contribute to stress - participating as a member of a multi-disciplinary team and acting as a 'change agent'. Dr. Karlinsky explored the change agent role. In 1943, Ryan and Gross published an article in Rural Sociology entitled "Diffusion of Hybrid Seed Corn

in Two Iowa Communities". This article identified the process associated with the diffusion of innovation and confirmed the often slow transition from awareness to adoption. The diffusion of innovation requires extensive communication including mass media and interpersonal channels. Change agents are individuals who influence clients regarding innovation decisions largely through interpersonal communication. In telehealth, the telehealth coordinators assume the role of change agent, formally or informally. The stress associated with this role is due to the disappointing rate of adoption (although usually too low, it may be too high). Understanding the factors that influence change agent success can reduce the stress. These include the following:

- The amount of effort given to contracting clients
- Assuming a client orientation rather than change agent orientation
- Working through opinion leaders
- Providing the subjective evaluation of peers
- Change agent similarity to client
- Credibility in client's eyes
- Increasing client's ability to evaluate innovation

The telehealth coordinator acts as a bride between two differing systems - the traditional physician-based delivery of healthcare services and telehealth. There is a risk of social marginality (not belonging to either) and the telehealth coordinator must recognize the world he/she is in or create his/her own world.

Dr. Bates discussed strategies for reducing stress by building successful interdisciplinary teams. Telehealth projects/programs have a variety of individuals at the management table, each with different values, priorities and issues. There is enormous potential for miscommunication. Team members values may support other areas more than a telehealth project; their culture may not value technological solutions; and they each have different perceptions of the value of time and money. It is important to work within recognized constraints such as nursing shortages during the summer months, grant cycles, call schedules, or other competing IS priorities. To prevent conflict, Dr. Bates recommended the following:

- Demonstrate understanding/support for different values and priorities
- Get time commitments on the table
- Negotiate win-win where possible so that individual agendas are met
- Be clear about importance of timing
- Ensure full support from supervisor

APPENDIX D - Co-Lead Presentation Summaries

Appendix D - Co-Lead Presentations

Consent - Mary Beth LeBlanc and Debora Robinson

The doctrine of informed consent has developed over time "as the primary means of protecting a patient's right to control his or her medical treatment". When reviewing the legislation specific to consent, there is continued reference to the provision of treatment.

A valid consent must be:

1. given voluntarily
2. given by a patient who has capacity
3. specific to treatment and provider
4. informed

The general rule of consent is that "a person must disclose all the information that a reasonable person in the particular patient's circumstances would want to know before choosing to accept or reject treatment". It is the obligation of the person providing the treatment to inform the patient and, in general, to obtain the patient's consent. This raises the question of whether the telehealth coordinator or the physician (or other healthcare professional) should be obtaining patient consent for a telehealth encounter.

Some important elements to consider in establishing a consent policy and procedure are the following:

- Obtaining consent - Who? When? How often?
- Documentation - content and procedure
- Security and maintenance - storage and access
- Photography/videotaping - purpose, ownership, storage, retrieval, and destruction
- Media - purpose, relationship between organization and the media

Consents were gathered from a number of telehealth programs and the elements of consent were considered as a result of this review. Sample documents, based on the collected consents and literature research, were distributed to workshop participants (see Appendix F). These included policy/procedure for consent, consent forms for telehealth and patient photography, elements of informed consent, substitute decision makers (SDM), and a telehealth information sheet. Consent forms do vary across Canada but the presenters for this session concluded that all consents should include the essential elements of consent and SDM information. Consent policies should be reviewed and approved by Risk Management and legal counsel.

Patient Registration, Documentation and Records - James Coyle and Liz Adair

The presenters developed an electronic survey to gather information on practices related to patient registration, documentation, storage of records and images, and the interface to billing and other health information systems. The questionnaire was posted on-line August 25 of the 34 surveys distributed were returned for a 74% completion rate. Program managers, supervisors and coordinators completed

surveys across the country. The co-leads presented preliminary findings but further analysis was recommended. Among the early findings were the following:

- 72% of respondents indicated that an outpatient form/facility record is generated for telehealth sessions
- Client consent is considered part of the telehealth record at the majority of near end (consultant/clinician) and far end (client/patient) sites
- Two or more forms are collected for each telehealth session by most sites surveyed
- The client is registered at the far end (client site) in 68% of cases; 16% of the programs surveyed reported the client being registered at the near end (consultant site) and 4% reported registering clients at both sites
- The patient record is stored at both sites in 46% of the programs surveyed with 29% at the far end only and 17% at the near end only; there were other locations or specific circumstances identified by several respondents
- The majority of respondents indicated efforts to integrate telehealth record into existing client records
- Client information related to the telehealth encounter is frequently distributed to an stored in multiple sites
- The telehealth coordinators are responsible for telehealth client information at 64% of sites surveyed
- The most common information shared between referring and consulting sites are consent, consult record/referral form and diagnostic results
- 96% of respondents indicated document sharing via fax; 20% use unencrypted email; 16% encrypted email; snail-mail is still used in many cases and only 8% have an electronic health record solution to facilitate information transfer
- National, provincial, network and facility policies influence information management for telehealth
- The telehealth coordinator plays an important role in maintaining policy for patient documentation and records related to telehealth

Job Roles and Responsibilities - Cathy Holmes and Stephanie Froissart

In order to determine the job descriptions, roles and responsibilities of telehealth coordinators, a survey was completed across Canada. Some of the findings are captured below (presentation can be found in Appendix D):

- 64 individuals or oganizations were targeted. 41 surveys were completed and of this number, 28 different job descriptions were found with 17 different titles.
- The majority of those surveyed have a clinical background (40%) and many have a variety of management experience.
- Many telehealth coordinators (60%) have been in their positions for a relatively short period of time, 1-5 years.
- Most telehealth programs have been in operation for this period of time as well, so the telehealth field is still relatively new.
- Telehealth coordinators are mostly female but the number of males in these position is growing.

- Education level of the telehealth coordinators range from high school diploma to Master's Degrees.
- The position of the coordinator is a multifunctional role:
  - Advocate
  - Trainer
  - Marketer
  - Coordinator
  - Manager
  - Scheduler
  - Other roles
- The common characteristics and skills found in the coordinators are:
  - Communication skills
  - Organizational skills
  - Good problem solver
  - Independent
  - Self-motivated
  - Team player
  - Interested in technology
  - Good interpersonal skills
  - Knowledge of the healthcare environment
  - Flexible
  - Collaborative
  - Management skills
- The position remains precarious and ill-defined
- There are many rewards to being a coordinator:
  - Cutting-edge of technology and new ways to deliver healthcare
  - Positive change from past positions which may have become routine
  - Ability to work with a multidisciplinary team
  - Ability to communicate and network across the country
  - Providing access of care to patients is rewarding
  - Professional satisfaction in bringing about positive change in healthcare
- Issues and Challenges:

1. Environmental-related Issues

- The healthcare system is already over-utilized and under-funded.
- The healthcare environment is slow to react to issues and problems and slow in the response to find solutions.
- There is a lack of understanding in the urban areas as to the challenges, issues and way of life in the more rural areas.
- Physicians are busy and often do not like change; therefore introduction of new technology and new ways to deliver care causes issues.
- There is a shortage of healthcare employees and telehealth often requires over-worked staff to take on additional duties.

2. Human Resources

- The addition of added activity and responsibility has many consequences.
- Often, there are no dedicated staff assigned to implementing and operating telehealth, therefore responsibility is vague.
- Very few coordinators have had any experience in telehealth or with the use of the required technology, leading to a steep learning curve in a short period of time.
- Coordinators are required to have broad skills in administration and management and many do not have that experience or training.

3. Organizational Issues

- Funding
- Remuneration
- Promotion of telehealth internal and external is required and not always a priority
- Change management is required to adapt telehealth
- Lack of space for telehealth equipment/rooms
- Not an agenda priority for management
- Guidelines and policies for telehealth are scarce
- Jurisdictional restraints

Further survey results were compiled and can be found in Appendix E - Job Description Survey - Strategies, Profile of Canadian Homo Telehealthus, and Map Roles.

Telehealth Awareness - Carol Fenton and Wendy Barker

Telehealth Coordinators play a large role in facilitating the adoption of telehealth by health professionals and encouraging the integration of telehealth into mainstream healthcare service delivery. Successful promotional events have included 'show and tell' or open house sessions to display the capabilities of the system to clinical providers, administrative staff, management, housekeeping/maintenance, community support groups and patients. Pamphlets, posters, local news media and monthly newsletters have been used to raise telehealth awareness. Physician champions are essential to overcoming physician resistance to the use of telehealth and should be identified early on to support the promotional efforts of the telehealth coordinators.

Teleheatlh Training - Angela Nickoloff and Audrey Huziak

A questionnaire was distributed to projects/programs across Canada to identify the types of training received by different staff members and the most effective training methods utilized. Most programs indicated one person designated as the 'telehealth coordinator' but the additional staff that receive training included physicians, nurses, counselors, diagnostic imaging technicians, educators, IT staff, administrative staff and community health resources. The types of training offered include program training, specific application training, and technology training. The most common people responsible for training were the technology vendors, regional/district telehealth coordinators and IT support staff. The most common training methods include live discussion/demonstration, hands-on practice, videoconference discussion and self-directed study. Training tools typically include technology manuals (vendor provided), telehealth program manuals/protocols and technology quick reference guides. In-

depth technical training may be 2-5 days in duration whereas typical end-user training may be as short as four hours or less. Evaluation of training is performed via verbal feedback (informal) in the majority of cases.

Challenges identified include the following:

- Different programs have different expectations of the roles and responsibilities of the telehealth coordinators - this impacts the type of training needed and who will be responsible for providing the training.
- Dedicated staff positions and funding to provide training is not always present
- Different material is presented to different audiences
    - Consider language and cultural barriers
    - Scheduling - availability
    - Varying levels of knowledge and experience
    - Staff turnover
    - Infrequent use of equipment - how to reinforce learning
- Some technology vendors don't yet appreciate the difference between videoconferencing and the use of videoconferencing for telehealth

Successful telehealth training programs included dedicated training positions, sufficient funding and time for program development.

Other Interoperability Issues - Doreen Tennant and Tina McKinnon

A questionnaire was developed and distributed to telehealth programs across Canada to explore the issues related to interoperability where telehealth activities cross provincial borders, governing agencies and ministries. Although there was limited response to the survey, it is clear that there is a significant amount of cross-provincial telehealth activity underway with a large number of clinical applications identified. The issues of highest priority for those that responded were:

- Physician licensure
- Credentialing of physicians participating in telehealth consultations
- Other healthcare professional licensing (e.g. Pharmacy)
- Medical orders across jurisdictions
- Different technology platforms
- Remuneration of health professionals
- Privacy and security
- Scheduling protocols (majority manual process)
- Patient registration

In general, there has been significant work done towards implementing policies and processes to support cross-jurisdictional activities and there were many common elements identified. The largest barrier is F/P/T policies and acts. The challenge is to find ways to share the work that has already been done and effect change were necessary.

APPENDIX E - Minutes from Breakout Discussions

Appendix E - Minutes from Breakout Group Discussions

Telehealth Consent Breakout Session

General Introductory Discussion:

- What are we obtaining consent for?
- Transparency
  - What is happening with information and how it is being transmitted.
  - Telecommunications issues
- Need to explain what is happening and how
  - One type of consent required for telehealth
  - Generic with regards to telehealth
  - Define what we are getting consent for
  - A lot was put in place when telehealth was new and we now have experience to influence decision
  - What is current practice?

Best Practices/Guidelines - "common approaches & successes"

- Must consider:
  - Provincial regulations
  - Consent to Treatment Act
  - Substitute Decisions Act
  - Freedom of information, privacy, and health information acts specific to F/P/T standards
- Person obtaining consent should be person providing treatment
- Consent may need to reference the sharing of information including:
  - Videoconference
  - Store and forward
  - Faxing
- Videoconference is the tool to provide treatment
- If treatment requires consent then normal practice should prevail
- Same people who get consent now would be the person to obtain consent for videoconference
- Inform about what videoconferencing is and what it means to the patient
- The form itself implies informed consent but real understanding may not necessarily be accomplished
- Risk management involved - patient informed (poster, handout, etc.)
- Important to give consistent information specific to persons using the system
- By attending telehealth encounter, implied consent applies

Lessons Learned - "what didn't work and why"

- Videoconference (via telehealth) is the tool to provide access
- If such medical act normally requires consent then standard practice followed

- Telehealth does not change normal practice guidelines
- Consent for videoconference is not necessary
- Providing information is necessary
- Integration is required to become a part of standard health care delivery

Common Process to Develop/Guidelines

- Are there information gaps?
    - Australia guideline (Literature review)
    - Similar examples (i.e. Alberta We//net)
    - Interpretation of work that is currently used
    - CMPA guidelines - 7/8 similar to what you do at doctor's office
- Needs to be consistent with F/P/T legislation
- Documentation required: need to develop a mechanism to provide detailed information to inform patient/users of risks and interaction guidelines (poster, pamphlet, handout, etc for consistency of information)
- Develop policy consistent with pre-existing legislation
- Mechanism to provide a standardized template for risks and documentation/information sheet that could be adapted for each province
- Generic information could be adapted for each jurisdiction
- Education and involvement of professional bodies and decision makers
- Integrate into existing policies where possible

Implications for a National Approach

- Guided by F/P/T clinical practices for medical treatment
- Integration into normal practice patterns to break down challenges to integration of telehealth into normal delivery
- Telehealth is no longer an experiment - does it still need to be looked at as an experimental process?

Outstanding Issues/Constraints

- Define acceptable practices
- Security and maintenance
- Issue of consent as a barrier to telehealth moving forward
- Telehealth equipment is a tool not the treatment (e.g., IV Therapy).
- Why change practice of interaction with healthcare provider for telehealth and have it different than face-face?
    - By having a written consent process, integration of telehealth not as transparent
    - Medium for a medical act and videoconferencing/store and forward is not a medical act
    - Using a tool to perform a medical act that requires consent then consent would follow
    - Once we define what we are getting consent for we are able to move

forward

- Human resource access (i.e., inputting information into Health Record) - What personnel will be involved in providing service (including non-health-staff) and release of information
- Linkages to all other policies/guidelines to develop consistency and templates that are national guidelines
- Implied consent - telehealth is no different to other healthcare services
- Should CST Policy Committee look at the recommendations from the findings and legal advisory groups?

Action Items/Next Steps

- Provide recommendations from group/session - the Coordinators group does not have the authority to move forward on these recommendations but would like support with same and a decision
- Involve provincial/territory/national decision makers, the CST Policy Committee and Board and others as necessary
- Literature review of other jurisdictions, e.g. New South Wales, Alberta we//net
- Professional practice associations and decision makers need to be involved in and support recommended guidelines
- Consent should not be a barrier for telehealth
    - Focus around integration into total health care practice by removing barriers

Consent Requirements for Videotaping, Store & Forward and Other Specific Applications

Issues for Discussion:

- Identify need for consent in special circumstances (e.g. Videotaping, S&F, promotional materials, procedures)
- Consultation with 2nd/3rd level hospital

Best Practices/Guidelines - "common approaches & successes"

For Education:

- Obtained legal opinion
- Need a release form for each participants that are specifically identified during the videoconferencing session (the form must be filled and signed)
- Must obtain consent prior to doing the videoconferencing session
- Posted a sign outside the room to inform participants
- Important to document prior to the session in case not able to reach the participants (due diligence)
- Consent is kept with the videotape
- There are some documents on the Internet to look at (i.e. Photography)

- General concern around the length of time it takes to inform the client
- Maybe should be looking at accreditation process (this would enforce the validity)
- Once the consent is established just stick to it

For Videotaping Clinical sessions (or digital imaging)

- Look at College of Physicians (for example, in BC they must obtain a consent every time they are doing a session)
- Need different consent form for assessment, evaluation, etc.
- In tele-emergency, taping the consent is useful for future consultation and training
- Some organizations have the consent included as a condition of employment and is done at sign-off time
- How long should the video be kept, when to erase it (look at current legislation) and provide information on how to destroy them
- Requires separate form for clinical, media, education, research, evaluation
- Include specific clinical applications in the consent form
- If you can't justify why you are recording then should you?
- Need to discourage videotaping unless necessary

Lessons Learned - "what didn't work and why"

- In Quebec, one group use separate forms for different applications (i.e., media, education, research, evaluation)
- Keep it simple, can do with only one form (like Tele-emergency group in Quebec)
- Try to keep it simple
- Consent may be a constraint
- Waiting to get the perfect consent. Prevents us from doing clinical applications (must be the same as face to face)
- Need to educate the users before the session

Common Process to Develop Policy/Guidelines

- Review other countries processes (i.e., Australia has been doing it for years)
- Review existing documentation for Patient Photography
- Review website www.ahima.org
- There is no need to reinvent the wheel
- Review applicable Provincial legislation
- Review Canadian Health Record Information
- When preparing the consent form, ensure you are using the appropriate literacy level (one group has been using 8yrs old level)

Implications for a National Approach

- National Telehealth guidelines
- Each province has different legislation (keep that in mind)
- Must have a generic approach and then adapt it to each province
- Examples of areas of speciality - Tele-homecare, Tele-Psychiatry
- Independent of telehealth, must obtain consent (for recording) because of Privacy legislation - this is a national requirement

Outstanding Issues/Constraints

- Do we need 2-3 consent forms? (videotaping, consult, research)
- In the Tele-emergency case, they simply added check box to their current consent form (Y/N)
- Look at current medical material as a basis on how to handle photography

Action Items/Next Steps

- Task a working group to tackle issues (need diverse representation also from the privacy division)
- Follow-up with College of Physicians for baseline/guideline
- Look in current medical literature for basis on how to handle photography

Patient Registration Breakout Session

Best Practices/Guidelines - "common approaches & successes"

- Registration at both facilities (much easier to register at both sites if both are healthcare facilities as processes exist)
- Register patient as on out-patient (registered in the Meditech system as either an out-patient or a telehealth patient)
- Register patient directly at the clinic (e.g. Dermatology, Psychiatry)
- Registration goes to Health Records Department and does not stay in the telehealth clinic

Lessons Learned - "what didn't work and why"

- Patients need to be registered! Most coordinators feel patients should be registered where they are located, except in the case of using videoconferencing at a non-health site. In that case, the patients should be registered at the physician site.
- Hospitals need to track patients' activity through a registration process, whether at the outpatient department or at the telehealth clinic for various reasons.
- In-patients do not require additional registration for telehealth encounters.
- Registration of telehealth patients should follow the process of the organization and should not be treated as an unusual process.

Common Process to Develop Policy/Guidelines

- Work within existing processes (i.e. integrate telehealth as a "normal" function of healthcare and not treat telehealth as a separate entity).
- Recommendations are made from the telehealth staff to the organization's Policy and Procedure group so that process can be formally established.
- Check with other programs
- Health Records and QA group work to change the registration process in an institution (e.g. Telehealth registration at the IWK was a catalyst to examine the registration process and it was found it was not effective. The entire registration process was changed and telehealth was included in that process.

Implications for a National Approach

- Need to define registration. Is it the start of the patient record or is it when a hospital number and chart have been started?
- Patient must be registered. Need to look at provincial regulations.
- All current methods of registering telehealth patients need to be reviewed for risks.
- Legal issues for telehealth are becoming more complicated, not less complicated. A review of practice outside our borders needs to take place.
- Review all cross border practices.
- The effect of registration on workload measurement and funding must be taken into consideration.

Outstanding Issues/Constraints

- Patient registration vs. telehealth registration.
- If patients register at the telehealth studio only, there is no record of the encounter at the "hospital level".
- Unless patients register with the hospital, there is difficulty in tracking workload.
- Registration often is accompanied by a billing code and telehealth sessions may take longer. Perhaps telehealth billing code is required?
- Hospitals often receive funding based on patient population. If telehealth patients are not registered there is no way to track them for use of hospital resources.
- If patients are not traveling, human resources and other resources need to be increased to handle the additional patients.
- Local site may have funding increased due to increased patient population but the "receiving site", which would have seen the patient in the facility if telehealth was not in place, may have funding decreased due to decreased patient population.
- Ethical and Legal issues (Where are the patients located? Who is responsible for them?)
- Occasionally telehealth patients are required to use a non-healthcare site such as a school, library, Daycare. Does registration then take place at the physician site?
- Often registration occurs at both sites out of habit, not best practices.
- Fear of lack of adequate documentation (common feeling for nurses due to their training).
- Some provinces have not defined telehealth therefore it is difficult to address issues such as telehealth patient registration.

Action Items/Next Steps

- Define registration
  - Ministry of Health in each province
  - Hospital acts
  - NIFTE
- Ministries of Health should offer guidelines in coding for telehealth (important for

workload measurement, funding and budgeting).

- Review of current practice in Canada and other countries (US, Australia)
  - NIFTE
  - CST Policy Committee
- Working group to coordinate and organize information and make recommendations on findings to CST Policy Committee and NIFTE. These groups will in turn develop national guidelines.
- Continue to register!
- Maintain best practices of the organization until guidelines are developed.
- Promote Electronic Health Record as a vehicle to organize all patient data.
  - Coordinators as advocates
  - CST

Documentation Breakout Session

Best Practices/Guidelines - "common approaches & successes"

- Basic overarching principles include mirroring normal processes where possible and maintaining the integrity of the health record
- No consensus on where patient record should reside but data (Liz & James) and group majority agree that patient site is more optimal for ease of information exchange and continuity of care

Example of documentation required for clinical encounter:
Far (patient site):

- Patient name and demographics
- Identifier
- Diagnosis
- Consulting/referring MDs
- Consent - telehealth, treatment, taping and/or other (unique Telepsychiatry consent form 14)
- Lab/X-ray results
- Medical history
- Physical findings
- Medical instructions
- Protocols
- Orders
- Discharge/follow-up
- Telehealth evaluation data
- Event record/transaction log
- Multi-media - images, video, etc.

Near (MD) site:

- Referral letter (may include request for additional information)

- Consent
- Routine recording of event (doctor's notes/comments)
- Physician orders/prescriptions
- Letter (dictation) - usually mailed or faxed - to referring MD and often multiple other sites (health centres, multi-disciplinary teams, etc.); this raises additional concern over security and confidentiality
- Many elements may exist at both sites

Lessons Learned - "what didn't work and why"

- Elements of information exist in multiple places
- There is a need/desire to mirror routine process which is often cumbersome
- Mirroring inefficiencies in current system
- Haven't addressed process reengineering because
    - Parallel systems don't allow us to eliminate 'old ways'
    - Little impact/power from telehealth group
    - Maintaining process may encourage 'buy-in'
- We are missing information - this impacts the ability to capture important data for other purposes than care (e.g. Billing, workload measurement)

Common Process to Develop Policy/Guidelines

- Much communication is required among everyone involved prior to telehealth activities so that all parties understand information requirements and flow

Implications for a National Approach

- Elements of information exist as a variety of sites due to requirements and constraints (e.g. Regulation, capital/funding decisions, legislation/policy)
- Move towards identifying an acceptable minimal data set for specific sites/purposes
- There is a need for more uniformity of policy
- Require awareness of variety of skills/backgrounds of telehealth coordinators as many collect physical/medical information while others are engineers and are only responsible for technology function
- Standardized EHR deployment across Canada will resolve a great deal of the confusion around patient documentation and registration

Outstanding Issues/Constraints

- Whose job is to ensure proper documentation in place for telehealth encounter? Many telehealth coordinators take on this role because:
    - As nurses, it's always been part of their 'duty' (not in telehealth coordinator job description often)
    - They want to keep the process as smooth and successful as possible
- Must also consider the following:
    - Existing privacy legislation
    - Information distribution - often to multiple team members - and confirmation of

- receipt (no clear role - some do, some don't
- EHR solution would eliminate many of the issues and inefficiencies but interoperability will be important
- Facility guidelines/provincial guidelines
- Funding impact - import/export relationships
- Human resources - roles/responsibilities/skills, shortages

Action Items/Next Steps

- Mirror routine practice
- Acknowledge that elements of information exist in multiple sites
- Patient documentation may or may not be a responsibility of telehealth coordinators but there is a need to ensure sufficient information is collected to:
  - Facilitate effective health care service delivery
  - Maintain integrity of the health care service delivery
  - Ensure continuity of care
  - Other - tracking/logs, billing, workload measurement, evaluation/QA
- Although no consensus, majority agree record should reside at patient site
- Identification of a minimal data set for various sites/applications to support policy development
- Maximize uniformity of policies where possible with the understanding that there are constraints such as legislation, regulations, skills/roles of telehealth coordinators and new and expanding paths of information distribution
- Raise consciousness about other issues that impact documentation and records such as funding
- Be proactive towards EHR initiatives - seek opportunities to work with EHR initiatives to ensure that telehealth data elements are integrated into EHR solutions

Critical Functions/Changing Role Breakout Session

When asked how they became Telehealth Coordinators, those in this breakout session had a variety of answers:

- Inherited the position as part of their existing role
- Applied for the position because it looked interesting, they could get away from shift work, it appeared to be an opportunity to learn new skills
- Were approached by management to consider taking the position

Best Practices/Guidelines - "common approaches & successes"

The group defined what they consider to be good approaches to telehealth, which helped to improve their role as coordinators.

- Telehealth coordinators' ability to function well within the organization is increased when there is management support.
- Central coordination of a program offers more organization and stability to the

coordinator.

- Telehealth strategic plan must fit within the organization's strategic plan and be supported by management and or government.
- There must be a team approach and supporting roles as the telehealth coordinator cannot manage all aspect of a program, solely.
- The position of the telehealth coordinator should be a budget line item and there should be funding for training for the coordinator initially to increase required skills (e.g.. Technical training, project management) and ongoing professional development in order to meet the demands of the changing role.
- Support for telehealth is usually more forthcoming if it is presented as a innovation.
- The organization and its stakeholders must value telehealth.
- There must be a communication plan for the dissemination of information and promotion about telehealth.

Core Competencies

The discussion about the core competencies of the telehealth coordinator was extensive and led to the conclusion that many job descriptions are available and there are many titles for the role of the coordinator. Presently some are called Telehealth Coordinators but do not have the same level of responsibility and do not lead nor manage programs. The consensus was that the Telehealth Coordinator position should be differentiated from other positions (e.g. Community Health Worker). Discussion also centered on how to ensure that coordinators have the required skills. The group determined that coordinators, through education and experience should go into the position with certain skills and others could be gained through professional development, e.g. Project Management. Listed are the core competencies/experience the group felt was necessary for a telehealth coordinator to have when entering the position:

- Communication skills (oral and written)
- Problem-solving capabilities
- Organizational skills
- Ability to prioritize
- Time management skills
- Flexibility
- Creativity and the openness to innovation
- Interest in technology
- Basic computer skills and the desire to increase the skills
- Management and leadership skills
- Healthcare background and knowledge of the healthcare environment
- Experience with the environment/culture or community (e.g. hospital, homecare environment)
- Value of patient care
- Interpersonal skills
- Strategic thinking and planning skills (ability to see the "big picture")
- Ability to think "out of the box"

- Must have credibility
- Enthusiasm and high energy levels are required

The differentiating factor between the Telehealth Coordinator and other support roles is "leading versus doing".

The Telehealth Coordinator position requires supporting roles to operate and expand the telehealth program. Listed are some of the supporting roles identified by the coordinators:

- IS (e.g. Help Desk Support, on the ground technical support, equipment maintenance)
- Administration (secretarial, financial, human resource)
- Scheduling
- Evaluation
- Management
- Communications and PR
- Clinical support (e.g. physicians, nurses and other healthcare professionals)
- Hands-on assistance (e.g. Telehealth assistant to turn equipment on for sessions, assist with training, etc.)

Lessons Learned - "what didn't work and why"

- It is not the educational background of the coordinator that is important, rather it is the experimental background and the skill set. Healthcare experience is a requirement.
- Telehealth Coordinators will gather knowledge, lessons learned and tips from other coordinators across the country and need to use the network of colleagues available to them.
- The differences between Telehealth Coordinators and supporting roles should be recognized.
- Telehealth Coordinators cannot do everything and support must be provided, starting at the organization's management level.
- Telehealth Coordinators must have a set of core competencies when taking on the position and a variety of skills.
- "Back-ups" for the Telehealth Coordinator should have extensive training as well.

Implications for a National Approach

- The title "Telehealth Coordinator" should not be coined and standardized as it will never fit into all organizational charts and structures and pay levels. However, the core competencies and skills should be defined and become standards for a job description.
- The titles and roles for supporting positions should be defined and become recommendations.
- Definition is required on the skills of Telehealth Coordinators at present and what the skill set should be and make recommendation on the professional development that may be required.
- The definition of the job description should not be so far-reaching as to limit those that could apply. In some areas, there are few very health care professionals and an

extensive, complicated job description may deter those healthcare professionals from getting involved in telehealth.

- The definition of the role, responsibilities and job description belongs to this group of Telehealth Coordinators and there is no need to pass along to other groups for assessment and recommendations.
- Telehealth should be integrating with other e-health job descriptions and a broader range of skills developed.
- A business approach should be taken and understand that roles will evolve and change. Telehealth is entrepreneurial at present but will become more mature. Roles of the Telehealth Coordinator will then be integrated into departments.
- Job classification should be based on provincial standards. However, normal classifications are difficult due to pay bands and there is the risk of inappropriate classification.

Outstanding Issues/Constraints

The Telehealth Coordinators discussed issues and areas of constraint, which they felt impacted their ability to perform at optimal levels:

- General lack of knowledge of telehealth within their organizations, communities and at the government level.
- Job descriptions change rapidly and the expectation to take on more and more responsibilities.
- Difficult to prioritize when they wear so many hats.
- Skill set for the position is not always there at the start, yet there is little time or funding provisioned for professional development.
- There is a steep learning curve and often coordinators are expected to "hit the ground running".
- Telehealth often doesn't fit into the overall strategic plan for the organization and is looked upon as a "pilot project".
- Telehealth can operate as a stand-alone entity and doesn't fit into the organizational chart, therefore not given priority, resources and the management of the program is vague.
- The position is often a reactionary role as there is little time or resources to do strategic planning.
- Half time does not work!
- Many job descriptions and those in existence may not match the organization's standard descriptions, leaving the Coordinator Role to be slotted into a level. Pay levels based on the organization's titles, may not reflect the true responsibility of the position.
- Majority of Telehealth Coordinators are not paid to match the level of skill and responsibility required for the position. Salaries vary across the country and there are no standards.

Questions Raised in Discussion (Food for Thought)

- Should the Telehealth Coordinator position be union or non-union?
- Should the Telehealth Coordinators group form a professional body?
- Will the role as it exists now, exist in the future?
- Should it be more than one role?
- What are Coordinators aspiring to be in the future?
- What training and professional development will be required as the position evolves and changes?
- Should we try to preserve the "role and title of Telehealth Coordinator" or should we be trying to preserve the skills, knowledge and expertise of the Coordinators and integrate within the healthcare system?
- Is certification required for Telehealth Coordinators?
- Should we attempt to certify if we believe the positions of Telehealth Coordinators will eventually disappear and become integrated positions.

Action Items/Next Steps

- Task analysis for existing Telehealth Coordinator positions. An expert and funding would be required.
- Task analysis should be done for supporting roles as well.
- A working group within the Telehealth Coordinators would require funding to take the time to review the analysis and determine the core set of competencies for Telehealth Coordinators.
- A Human Resources Specialist should assist with the process of defining the roles, responsibilities and job descriptions.
- Check re funding from Human Resources Development Canada

Human Resource Challenges Breakout Session

Issues:

I. Recruitment and Retention
   - Employment issues such as union/non-union, seniority, etc.
   - Where do coordinators fit into organizational structure
   - Lack of secure funding for salaries - vulnerability, 'risky'
   - Lack of understanding by human resource personnel - impact hiring, employee satisfaction, ongoing support
   - Finding the right skill set - 'bridging' function, 'change agent', soft skills

II. Stress/Burnout
   - Multiple tasks and roles is primary 'stressor' - juggling time, different priorities and values for different roles (e.g. researcher, nurse, manager - telehealth coordinator is often all of these)

III. Professional Development/Education
   - What skills to grow?

Best Practices/Guidelines - "common approaches & successes"

Recruitment and Retention

- Money
- Rewards & recognition
- Dedicated staff - added full-time positions for special projects
- Mentoring, peer support, collaboration
- Support of champions
- Clear definition of role and accountability
- Senior management support
- Right people in key positions
- Communications
    - I. Meetings
    - ii. Bulletins, memos
    - iii. Updates
    - iv. Published evaluation
    - v. Marketing plan
- Excitement about new opportunities - 'cutting edge'
- Include telehealth in strategic plan
- Training for nurses, MDs, CHRs in school - earlier exposure to technology
- Include in general hospital orientation
- Conferences
- Preparation and orientation

Stress/Burnout:

- Peer support both formal and informal
- Training including soft skills, project management, facilitation, etc.
- Delegate
- Just say no
- Push efforts on sustainability
- Clearly defined roles
- Clear channels of communication
- Clear organizational chart
- Understanding/maintaining scope
- Clear business/program plan
- Balanced life
- Countering 'marginalization'

Professional Development/Education:

- Accreditation - no!
- Certification - maybe
- Communities of Learning e.g. University of Alberta

Lessons Learned - "what didn't work and why"

- Peer support is important
- Need training earlier in career
- Organizational (and beyond) understanding of telehealth - how to communicate (roles, complexity, values)
- Operational issues are key stressors 'day-to-day' e.g. Scheduling - need to address these issues
- Invest in appropriate resources (people, technology, scheduling solutions, etc.)
- Credibility is important
- Back-up is important - train-the-trainer with multi-disciplinary approach - clinical, operational, technical
- Integration of role - how?
- Sustainability is a barrier

Implications for a National Approach

- Accreditation for Telehealth Programs may bring more credibility
    - Can the telehealth coordinators input be incorporated into NIFTE guidelines
    - Focus on process, programs
- The need for telehealth policy at a national level - how do coordinators feed into policy development e.g. Cross jurisdictional licensing
- Maintain flexibility and scalability
- Certification of staff?
- Would memberships in other national organizations be valuable - networking and certification e.g. ONIG/NCAN,

Outstanding Issues/Constraints

- Is it easier to train healthcare staff on technology or train technical folks on health?
- Sustainable funding doesn't exist - vulnerable
- Evaluation data is outstanding
- The need for a stronger voice for CST - advocacy/authority

Action Items/Constraints

- Include telehealth in facility/program/regional strategic plan (demonstrates support and long-term commitment and allows planning efforts)
- Provide telehealth training/exposure in medical/nursing school - encourage as routine part of practice
- Telehealth Accreditation - NIFTE
- Telehealth Coordinators special interest groups
- Use technology to link coordinators and share knowledge
    - Current website - safe
    - Updated contact list on web (CST?)
    - Program information
    - Project information with updates

- Telehealth Partner Portal forums
- Contact list managers
- On-line scheduling software

Telehealth Promotion Breakout Session

Issues for Discussion:

- Key issues and communication strategies to promote telehealth awareness and knowledge sharing.

Best Practices/Guidelines - "common approaches & successes"

- Create an e-learning website. What is Telehealth? Case studies.
- Developed Patient Pamphlet
  - available at physician offices and health offices
  - send to client prior to the session
  - contains generic information about Telehealth in general
  - include knowledge consent - more information with pictures
- Presentation during orientation session for new staff (also done via video)
- In Nova Scotia with the Pre-op project, display storyboard (poster)
- Telehealth Awareness Month
  - packaged general information
  - how many sites available
  - developed crossword puzzles
- Produced quarterly newsletters for the public (what is happening just to stimulate their thinking and interest) (Outreach program)
- Telehealth tips of the month (done on-line, also weekly, sent to all hospital staffs)
- In New Brunswick, produce Communication Plan for each project (look at both internal and external stakeholders)
- Yukon Medical Association - posting in their website for education sessions
- Conducted Public education sessions
- Produced posters every month (internal use - who, what, when & where)
- Subscribed to Infomercials on local channel
- Attended all regional meetings and presented 1 application every time for Telehealth (demonstrated the benefits of using it)
- Organized communication plan (leave something with the participants - handout)
- Information on accredited document
- Telehealth is part of the strategic plan
- Public must register for open house to attend public sessions (sharing with the physicians as well)
- Building Testimonials
- Organized focus group (helped reach the right people)
- Published experience with the community - means of linking

Lessons Learned - "what didn't work and why"

- In Quebec, went too fast with mass media and was not ready to deliver on time
- Use the baby step approach, start local, provincial, etc in promoting
- We are not teaching Telehealth in our Nursing Schools and Medical Schools
- Having residents go to remote sites
- Sharing failure stories is very important
- In terms of evaluation, must look at what you are doing and finding out if it is working
- Need to be more international - promote to organizations that are giving funding

Common Process to Develop Policy/Guidelines

- Use Communication Plan
- Partnership with other organizations in order to facilitate changes (outside opinion)
- Education

Implications for a National Approach

- Awareness to teaching schools
- Involvement of National Professional body
- Maybe Health Canada should consider having Telehealth month
- Other funding organizations should promote projects under them
- Involve throughout the entire project
- Global Picture (how do we see ourselves at the national level)
- Keep in mind that Health is a provincial matter (work with provinces & territories)

Outstanding Issues/Constraints

- Budget - there is not much money set aside for promotion
- Identify communications plan and funding requirements in project proposals for dissemination of information during and at the conclusion of projects - need to convince funding agencies that this is important if not part of initial invitation for proposal
- Obtain subsidies from funding organizations (what they do to promote the sustainability of what they funded)
- Understanding your target audience
- Don't necessarily have the background needed to build a communication plan
- Lack of personnel

Action Items/Next Steps

- Establish a working group to create a Telehealth video and general PowerPoint presentation
- Forum over the net (need to exchange information on a continuous basis)
- Need to define ourselves more clearly
- Need more opportunities for Telehealth coordinators to share knowledge and experience
- Success stories made available to the group
- Create a bulletin board on CST website
- Need training and workshop for all the different roles the Telehealth coordinators are required to play
- Identify existing training/workshop opportunities

Telehealth Evaluation Breakout Session

This group began by identifying the issues they felt were important in the areas of telehealth evaluation and quality assurance/improvement.

Results

- There is currently a lack of evidence to support cost-benefit and patient outcome data in telehealth
- Need to be clear about whether the cost-benefit factor we speak about in our evaluations is in reference to the patient or the region as the difference impacts both the design and the analysis

Purpose

- Need to determine the relevance of the evaluation tools and why they are being used
- Need to address the issue of why we are evaluating - is it because we have to or because we think it is important
- Need to determine the focus of our evaluation work - are we evaluating the technology, the program, or the client satisfaction
- Important to consider what all stakeholders want out of the evaluation and design appropriately
- Need to move beyond proof of concept in our evaluation as we are no longer focused on pilot projects

Funding

- Most programs are often under-funded and even though evidence based evaluation is required, funds don't necessarily exist to support it
- It is felt that people in telehealth have been evaluated to death therefore it is difficult to get people to participate in evaluation
- It is difficult for the client to remain objective if they are paying for the evaluation - this also presents a potential bias

Design

- There exists a lot of bad research design which has an impact on the overall evaluation of telehealth
- There is often a misunderstanding of what evaluation and research terms mean which in turn leads to poor design and analysis
- The entrepreneurial spirit sometimes interferes with evaluation design
- A standard process for evaluation need to be developed so data can be aggregated with other jurisdictions thereby enabling the results and analysis to be more substantial
- There is a lack of expertise in telehealth research and evaluation on many teams which ultimately impacts the quality and understanding of the evaluation

Dissemination

- Research and evaluation often involves an academic therefore there are issues such as

publication rights and ownership issues that must be addressed

Other

- Evaluation is often not integrated with program development so benefits are not as strong or as useful as they have the potential to be
- It is important to link the purpose of the evaluation into quality improvement. It should also be tied to the goals and objectives of the project which must remain constant and not change mid stream
- Need to determine a process for how research and evaluation fits into the ethics review process
- Need to determine if telehealth belongs in the "healthcare toolbox" before we can move further in evaluation of programs and frameworks - it has to be better integrated in the system

Best Practices/Guidelines - "common approaches & successes"

- It is critical to identify who the evaluation is for
- Good evaluation will focus on
  - User satisfaction component
  - Saving money
  - Meeting goals and objectives
- Good research and evaluation design must be valid and reliable
- Evaluation must be stakeholder driven
- Research and evaluation must have a meaningful dissemination plan

Lessons Learned - "what didn't work and why"

- It is critical to get the research and evaluation component planned and integrated from the start and not wait until the end of the project
- Must ensure that the evaluation tool(s) is pre-tested
- Vendors should be included as part of the evaluation process
- It is important to include both a formative and summative evaluation component

Common Process to Develop Policy/Guidelines

- Evaluation must be consistent with national standards and guidelines such as the Canadian Evaluation Society Guidelines
- Need to develop a set of guidelines for evaluating telehealth
- The evaluation process must include end users and be stakeholder driven

Implications for a National Approach

- Ensure individual telehealth program research and evaluation results can be shared nationally
- Ensure the telehealth evaluation tools are culturally and regionally sensitive
- Recommend the use of comparable evaluation tools so comparisons can be made

across programs/regions
- Recommend the use of common indicators and a common evaluation framework
- Ensure there is room for custom requirements within common tools

Outstanding Issues/Constraints
- Telehealth coordinators have no research or evaluation background which impacts on many issues
- The evaluation often has to be conducted so simplistically (in terms of literacy level) that the information that is required is not always addressed

Action Items/Next Steps
- Include research and evaluation tools and reports on a national website (CST) with links to other relevant sites
- Include national representation of provincial/territorial experts in any development of research and evaluation standards
- Determine what CHIPP's plans are in terms of how they will be disseminating evaluation results and determine if there is an appropriate connection to this
- Review what is going on in other jurisdictions and determine how this may influence or guide telehealth's research and evaluation process
- Develop a database of validated tools that is accessible to everyone
- Support the NIFTE initiative in developing criteria for accreditation

Training Telehealth Coordinators Breakout Session

Best Practices/Guidelines - "common approaches & successes"
- Ensure that training addresses the hearing, doing and seeing components of learning
- Ensure the alternates to the site coordinators receive the standard training process
- Ensure the training is both appropriate to the audience and specific to the application
- Develop a reference manual to supplement the training process
- Ensure that training is ongoing and not a one time deal
- The follow-up component to the training is critical
- The training tools must be available for "just-in-time" training as there is often an immediacy to telehealth training

Lessons Learned - "what didn't work and why"
- It is critical to know your audience and how they are going to use the equipment
- Prepare simple documentation for trainees to take away as reference material
- Include a hands on component to the training
- The training should take place in safe environment where trainees feel comfortable in making mistakes
- Ensure the training is cultural and language appropriate
- It is necessary to train those within the system as well as the telehealth coordinators
- The training should not only be technical

- The promotion piece should also be included in the training

Common Process to Develop Policy/Guidelines

- Identify the core competencies/minimal data set required to work in the telehealth area and connect this to the job role
- Provide training that is flexible in terms of content and delivery

Implications for a National Approach

- There is potential to learn from and access program from other groups who offer training in areas that are not specific to telehealth yet are a critical component of the telehealth training e.g. management and leadership training
- It is not necessary to have a training program specifically for telehealth coordinators but there are some core competencies that will require training
- Important to integrate a prior learning assessment component and enable coordinators to receive recognition for skills that are brought into the job
- Training must be flexible, self-directed and accessible
- There should be minimal requirements developed to work in a coordinator capacity e.g. telehealth operator, site coordinator and program manager

Outstanding Issues/Constraints

- Due to many other commitments coordinators have little time to deliver training
- Coordinators don't necessarily have a health background
- Training may require several different content areas and delivery mechanisms depending on the audience it is being developed for
- Training must address issues such as computer skills
- It is important to remember that coordinators are not necessarily trainers and therefore do not have skills in this area
- There is a huge challenge in keeping a training manual up-to-date
- Training should be modular based (e.g. technology, promotion, project management, evaluation, leadership, communication, ethics, security, confidentiality)
- There is often no budget allotted to provide training to keep people
- Telehealth coordinators require different kinds of training depending on their core competencies therefore should be careful of standardization of training

Action Items/Next Steps

- Define job roles e.g. what a telehealth operator, site coordinator and program manager is
- Develop consensus on minimal data set/competencies that are expected to work as a telehealth operator e.g.
    - technical skill requirement
    - experience in a healthcare setting
    - understanding of ethics, privacy and confidentiality
    - good interpersonal and communication skills

- Develop minimal data set/competencies for the site coordinator and program manager
- Explore what options exist to access other types of training from other professions or regulated and unregulated groups

Training Other Telehealth Staff Breakout Session

Issues for Discussion:

- Issues and approaches for training other Telehealth staff (such as Medical directors, relief for coordinators, technical, back-up staff, physicians, users, etc.)
- Operational priority for 7 provinces and 3 territories. All Telehealth programs have some training in play either formal or informal. Best approach: clinical, administrative, organizational, technical aspect of Telehealth.

Best Practices/Guidelines - "common approaches & successes"

- Have key individual come in at least 15 minutes prior to starting the session
- Provide handout to presenter prior to the session (also to Moderator)
- Tips for Moderator
- Offer centralized scheduling service
- Have technicians available when conducting clinical applications
- General project information for Medical directors and advocate (how to promote program, press launch, reality, limitations) - This is a 2 hour session
- Help desk currently ran by technician (they were trained by the vendor) - This was a 2 day training session
- Trained by the vendor to support the equipment
- Troubleshooting process in place
- Meeting with clinical areas - break it down (details on how to use the equipments - basic functions)
- Explain who is responsible for what to avoid any confusion
- Clinicians have to do it amongst themselves
- Quick-to-meet on the net (scheduling tool) - find out what is available. Education session available on how to use it
- 1st training session done on site - 1 hr duration (use multiple remote controls so everybody gets to play with it - very hands-on approach)
- 2nd, 3rd, 4th sessions are done via video. Cover elements such as: dial-in, recording, etc. - ½ hr duration per session. Frequency - Once every 3 months - Audience - site secretary, nursing staff and others at site
- Another group is using a Modular approach. Session 1 covers videoconferencing basic functions and etiquettes. Session 2 is clinical base and covers S&F, medical peripherals). Very hands-on as well.
- Provide step-by-step instruction (form, contacts, process)
- Quick reference guide produced by the vendor - color & laminated - attached to the machine.

Lessons Learned - "what didn't work and why"

- Define your services and responsibilities clearly
- Coordinators receive training and then must train their back-up and others on usage (results in inconsistency and dilution of information)
- Coordinators are not necessarily good trainers
- Complicated process for booking Telehealth session with other sites and testing
- Hand hold physicians to make it easy and then stick with the process
- Physicians are not interested to know how it works as long as it works
- Training adapted to clinical, administrative, organizational and technical needs
- Focus on other elements as well like scheduling system
- To address the problem of staff turnover and increase retention, must have refresher sessions
- Have some materials available (such as: cheat sheet, reference manual, quick reference,

etc)

Common Process to Develop Policy/Guidelines

- Must have trained IT support for existing equipment
- Process for troubleshooting (internal as well as external including escalation)
- Ensure you have key interest people
- Identify alternate staff (back-up)
- Involvement of site coordinator is crucial (also requires the tools to train effectively)
- Empower your operators
- Keep it simple
- Target audience and content must be specific

Implications for a National Approach

- Training must be customized
- Recommend dividing training per application types (i.e., education, clinical, etc.)
- Have a marketing approach
- Use the resources that are already available out there

Outstanding Issues/Constraints

- Accreditation/Certification
- Still don't know who we are
- Linking with communities
- Lack of people with technical expertise
- Security of the system
- Funding

Action Items/Next Steps

- Need Tool box (i.e., education, clinical, etc)
- Conduct Peer review and do Train-the-Trainer
- Have central coordination for sharing on website
- Put together a training standard committee
- Conduct Train-the-Trainer but identify the right trainer first
- Mentoring program
- List of available mentors on CST site
- Conduct workshop on how to set-up training
- Attend upcoming training seminar during CST conference (NorthNetwork)

Interoperability Breakout Session

Issues for Discussion:

There are many issues of cross-jurisdictional interoperability, which affect the telehealth coordinators' ability to move telehealth forward and integrate it into the present healthcare system. As the issues are too numerous to cover in one session, the following were the focus for the breakout session:

- Licensure (physician and other clinicians)
- Credentialing
- Reimbursement (physicians and other clinicians)

Best Practices/Guidelines - Licensure/Credentialing

- Licensure is in place to protect the public and it must be as stringent in telehealth.
- In the US, 14 states use cross-jurisdictional licensing for nurses in telehealth.
- Europe is more advanced with cross-jurisdictional licensure.
- Australia and New Zealand have a mutual recognition for licensure for physicians.
- In Quebec the guideline for physician licensure is that he/she is licensed where they reside and the telehealth patient is registered at the physician site.
- Physicians must be credentialed in Nunavut in order to practice and use telehealth.
- Some programs have adopted the practice of getting a letter from the MAC that states a particular physician has been credentialed to practice in particular facilities within their program (following stated criteria).
- River Valley Health Region in New Brunswick takes a broader approach by having a letter from the MAC to cover all physicians in their region, which states they are licensed to practice telehealth in the province of New Brunswick.
- For nurses involved in triage call centers, the Canadian Nurses Association and the Canadian Nurses Protective Society have developed a by-law which states the nurse is governed in practice in the province where she/he resides.
- Nurses involved in Home Care in New Brunswick are also governed where they reside, even though some of their patients may be in Nova Scotia (e.g. the nurses use the technology (phone/videoconferencing) to contact their patients in Nova Scotia).

Best Practices/Guidelines - Reimbursement

- Pay all physicians for sessional, per diem/day and include telehealth consultations. This way they are paid for their hours worked, whether face-to-face or via telehealth.
- Bill by code, as per regular sessions, determined by the provincial MOH.
- Determine hourly rate for telehealth sessions based on the additional time it takes to do a telehealth consultation.
- Pay the consulting physician and the referring physician.
- "Trade off" sessions from one institute to another for CME sessions (no payment exchanged).
- Regions within telehealth programs often absorb many of the costs for community health/support groups as a support to improvement of local community health

Lessons Learned - "what didn't work and why"

- There is a lot of work required on many levels to ensure these issues are addressed.
- Reimbursement and other interoperable issues will be dealt with as telehealth becomes more readily accepted.
- Pressure is required from many jurisdictions/disciplines in order to attract government attention to deal with these issues.
- As some programs are paying physicians to do telehealth, it is difficult to change this practice, as the expectation has been set.

Common Process to Develop Policy/Guidelines

Although there are no national standards or guidelines in place to date to deal with the issues of reimbursement, credentialing and licensure, some groups are working through their own means to attempt to address the challenges.

- The Children's Telehealth Network Steering Committee has worked with the IWK and the River Valley Health region to put forth recommendations to address licensure (i.e. letter from MAC to cover physicians working in telehealth across the borders).
- The Advisory Committee on Informatics and Emerging Technologies may address policy issues.
- CST Policy and Standards Committee is also reviewing such issues.

Implications for a National Approach

- As CHIPP has been designed for and in turn supports and funds cross-jurisdictional programs, Health Canada will need to review the issues and work with telehealth experts to reach consensus and answers to the issues of interoperability, licensure and credentialing and other interoperable issues.
- Government is committed to provide all citizens with access to basic health care. Telehealth supports this mandate but cannot move forward while these issues remain unresolved. Government needs to remove the barriers to telehealth.
- National licensing standard will need to be developed. In the interim, however, the best practice of keeping the process as simplified as possible so as to keep costs down and less complicated, should be followed.
- By-laws require revision to include telehealth.
- Solutions to some of these issues may assist in solving larger issues such shortage of healthcare professionals in more remote communities, gaps in healthcare delivery.
- Telehealth issues need to get on the agendas of OHIH, ACHI and other organizations. The questions remains, how to ensure that these issues are indeed addressed at these levels?
- Telehealth needs to be viewed as a tool to provide healthcare services and be integrated into the present system.

Outstanding Issues - Licensure/Credentialing

- Provinces and territories that do not "import" medical services do not deal with licensure issues. However, if standards were in place, it is anticipated that those same areas would indeed use

the services of other clinicians, outside their borders.

- Liability insurance is in place for physicians in Canada who practice telehealth. However, it is not clear if other healthcare professionals are covered through their own Associations and Colleges.
- Process of identifying credentials can be time consuming.
- Cost - Who absorbs the cost for licensure and credentialing? The telehealth program? The Ministry of Health?
- Physicians need to push their agenda with their colleagues and Colleges.
- Professional bodies hesitate to change as the processes often drive their mandate for existence; (e.g. Physician Colleges are in place for regulation and licensing in each province).
- Licensure is an issue facing other healthcare professionals as well.
- Some areas have arrived at temporary solutions, as there is no national solution. This only enforces the segregation of the areas from one another and non-standard approaches.
- Licensure for telehealth is not an important agenda item for many, including government.
- There are many forms of "health practice" such as Internet health services, and private healthcare practitioners. Negative incidents, which may occur with these groups who may not be bound by regulations and standards, sets up a "fear factor" for many. Telehealth may be viewed in the same light, thus making it difficult for decision-makers to decide on national standards.
- Federal government provides funding to implement services where cross-jurisdictional practice is required (i.e. CHIPP funding guidelines stated that multidisciplinary, cross-jurisdictional projects would be funded), without providing solutions on how to deal with these issues. Each telehealth program/project is left to "figure it out". Some groups may develop their own guidelines but there is no national standard. Other groups may decide the risk to be too great, thus preventing equity access to care for some patients.

<u>Outstanding Issues - Reimbursement</u>

- The physicians who receive fee-for-service vs. salary are determined by the MOH. In only a few provinces, fee-for-service physicians are allowed to claim for telehealth consultations. Salaried physicians are paid, both for face-to-face practice and telehealth consultations. This is seen as discrimination by some.
- Different methods are in place across the country, to reimburse healthcare professionals in telehealth:
    - Some projects cover the costs of reimbursement through their project/program funds
    - Some jurisdictions charge other jurisdictions.
    - Some areas are funded on patient population and telehealth may increase the patient population to one facility, even if they are seen by telehealth.
- Some programs pay physicians an additional "telehealth fee" to compensate for the extra time it takes to do a telehealth consultation, setting precedence. Physicians in other programs may begin demanding the same.
- There are no guidelines to reimburse for sessions other than clinical, e.g. case conferencing, education sessions. Some programs reimburse and others do not.
- Much of telehealth to date has been good will (e.g. physicians offering to do consults for no

compensation) but this cannot continue indefinitely.

Action Items/Next Steps

- Get on government agenda through consistent and constant pressure from various groups (CST Policy and Standards group, physician and other healthcare professional associations/colleges).
- Develop a Task Force Group with representation from all groups affected by these issues.
- The Task Force Group to research and write a position paper to present to government.
- Get government billing agencies involved to assist with the issue of reimbursement.
- Develop a template of contract agreements for service for physicians and other healthcare professionals involved in telehealth.
- Develop a cross-jurisdictional inventory of all interoperable issues (i.e. inventory of equipment, bridges, contracts and other areas). This information will assist in understanding to what degree cross-jurisdictional activities take place between projects, programs and provinces and what other issues require attention, outside the issues of licensure, credentialing and reimbursement.

APPENDIX F1 -Job Description Survey - Strategies

The Quest of the "Homo-Telehealthus" - Who are they and what do they do?

Objective

1. To identify critical functions for successful operational telehealth;
2. To identify human resources issues for telehealth programs and strategies to manage these.

List of strategies proposed by the respondents:

What kind of successful strategies are you or have you employed in managing these issues?

Communicate!
- Memos to physicians;
- Articles in internal newsletter;
- Publish evaluation results;
- Organise staff meeting on regular basis;
- Give feedback to team;
- Print pamphlet;
- Organise information sessions to all members of facility;
- One on one meetings;
- Have a marketing plan;
- Organise virtual meetings;
- Communicate your vision for future;
- Keep bugging!

Delegate!
- Some work to clerical staff;
- Distribute the workload within team.

Collaborate!
- Talk to other coordinators for their experience;
- Work with districts to demonstrate your needs;
- Participate in different committee with other telehealth actors;
- Make friend with people from other departments.

Learn!
- Go to conferences and seminars;
- Keep time for training.

Get help!
- From university programs to facilitate implementation;
- Apply for grants;
- Develop software to facilitate schedule.

Build a strong team!
- Hire technical people;
- Look for supportive people;
- Provide support (including moral).

Be strategic!
- Include telehealth program in strategic plan;
- Develop protocol and guidelines;
- Evaluate activities.

Positive attitude and persistence in promoting telehealth.

APPENDIX F2 -Profile of Canadian 'Homo Telehealthus'

Profile of Canadian Homo Telehealthus

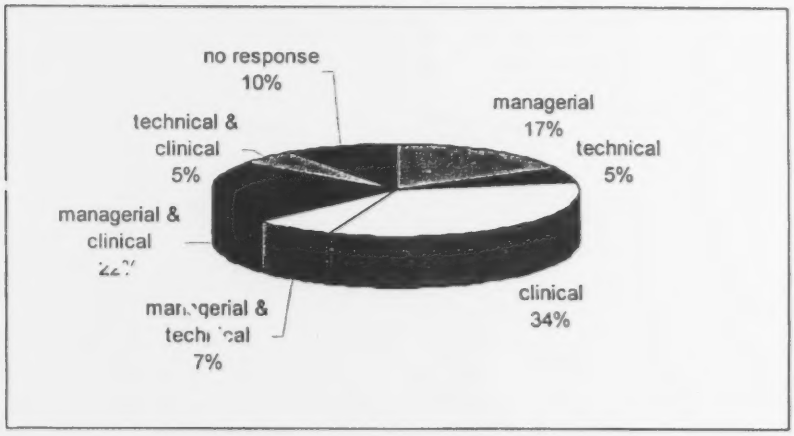
The survey was sent to **64** Homo Telehealthus towards Canada.

We received 41 responses (***n = 41***).

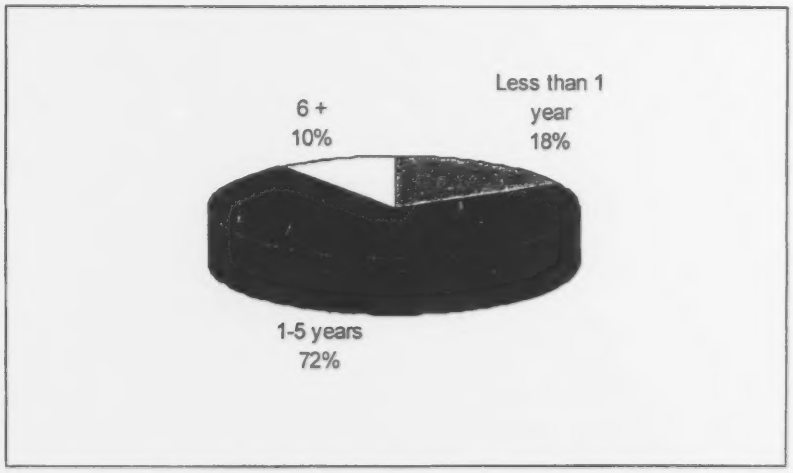
Location of respondents

British Colombia: **7.3 %**	Nunavut: **2.4 %**	Alberta: **19.5 %**
Manitoba: **10 %**	Nova Scotia: **10 %**	Quebec: **17 %**
Ontario: **17 %**	Saskatchewan: **2.4 %**	New Brunswick: **7.3 %**
Northwest Territ.: **2.4 %**	Newfoundland & Labrador: **2.4 %**	Yukon: **2.4 %**

Background of Homo Telehealthus



Experience in the field of telehealth



Telehealth has been operational in the Homo Telehealthus facility for:

14.5% less than 1 year

51% between 1-5 years

22% 6 years and more

10% did not answer

Profile of the Homo Telehealthus' facility

29% of Homo Telehealthus are working in a facility located in a rural area.

51% of Homo Telehealthus are working in a facility located in a urban area.

12 % are working in both rural and urban facility.

7% did not respond to location of facility.

17% of Homo Telehealthus are working in a University center.

Appendix F3 - Sample Consent

Telehealth Consent Sample Documents

Mary Beth LeBlanc, RN, BscN
District TeleHealth Coordinator - NS
Debora Robinson, RN, BscN
SWOTN Clinical Manager - ONT.

Telehealth Coordinators Workshop
CST Vancouver 2002

Policy & Procedure
Consent to Telehealth Consultation / Examination

Policy:
Consultation/examination with a healthcare provider using Telehealth videoconferencing can process only with the informed consent by the patient (if capable) or the substitute decision maker (SDM) (if the patient is incapable).

Purpose:
To ensure that:

1. The patient or the SDM understands the process of a Telehealth Consultation/Examination.
2. The patient or SDM is aware of the potential advantages and disadvantages of a Telehealth Consultation/Examination.
3. Informed consent is obtained from the patient or SDM prior to a Telehealth Consultation/Examination

Definition:
Telehealth Consultation/Examination is the use of the communications and information technology to deliver health and healthcare services and information over large and small distances.

Consulting healthcare provider is a healthcare provider who provides consultation services.

Referring healthcare provider is the patient's current healthcare provider who requests consultation services from another health care provider.

Healthcare Team is comprised of healthcare providers that provide direct care to the patient, e.g.) physicians, nurses, occupational therapists, registered dieticians, pharmacists, and social workers.

Substitute Decision Maker (SDM) is the individual responsible for decision making for an incapable individual (See Sample Documents).

Procedure:
1. The site coordinator will provide a copy of the Patient Telehealth Information Sheet and explain to the patient/SDM the:
   - purpose for using Telehealth Consultation/Examination.
   - advantages and disadvantages of a Telehealth Consultation/Examination.
   - videoconferencing equipment.
   - Telehealth Consultation/Examination may be stopped at any time by the patient or by the referring/consulting healthcare provider, with the option to resume the consultation/examination at the consulting location.
   - informed consent may be applied to ongoing Telehealth Consultation/Examination referrals.

- informed consent for ongoing Telehealth Consultation/Examination will be reviewed and discussed with the patient/SDM every three months i.e.) A renal dialysis patient's regular appointments with a nephrologist.
- written informed consent must be obtained if the patient is referred to a different healthcare provider.
- patient photography requires a separate consent (See Policy & Procedure - Consent to Patient Photography; Consent to Patient Photography; Patient Photography Information Sheet).

2. The site coordination will:
   - provide the opportunity for the patient to have their questions answered.
   - obtain informed written consent if patient/SDM agrees to participate in the Telehealth Consultation/Examination.
   - ensure the original consent is in included in the patient's health record at the referring location.
   - fax the consent to the consulting location for inclusion patient's health record.

References:

Consent to Treatment Act, 1996.
Substitute Decisions Act, 1992.

Addressograph

Consent to Telehealth Consultation/Examination

1. I, _____ hereby consent to
   Patient / Substitute Decision Maker
   a Telehealth Consultation/Examination on _____
   Patient Name
   by _____.
   Healthcare Provider / Healthcare Team

2. _____ has explained the process for a Telehealth
   Site Coordinator / Designate
   Consultation/Examination to me. I have read the Patient Telehealth Information Sheet and understand the information given to me. I have had the chance to ask questions and have had the questions answered to my satisfaction.

3. I understand that the healthcare provider that I have been referred to will be given access to my personal health information.

4. I understand that my personal health information will be stored in my health record at both the consulting and the referring locations.

5. I understand that my personal information will be held in strict confidence consistent with hospital, legislative and professional standards.

6. I understand that the healthcare provider that I have been referred to may be at a teaching center. I understand that Residents, Medical Students, Clinical Fellows or other healthcare providers may observe or take part in the Telehealth Consultation/ Examination. I also understand that the healthcare provider at a teaching center may delegate the responsibility of the Telehealth Consultation/Examination to another member of the healthcare team.

7. I understand that the Telehealth Consultation/Examination may be stopped at any time by me or by the referring/consulting healthcare provider, with the option to resume the consultation/examination at the consulting location.

8. I understand that I may be asked to give separate consent for patient photographs, videography and/or audio recording taken during my Telehealth Consultation/ Examination.

_____ _____.
Date Signature: Patient / Substitute Decision Maker

_____.
Print Name: Patient / Substitute Decision Maker

_____.
(Relationship if signed by other than patient)

Patient Telehealth Consent Information Sheet

What is Telehealth?

Telehealth uses cameras and televisions to connect patients to health care providers at distant locations. The Generic Telehealth Network will allow care closer to home and patients will have the opportunity of seeing, hearing and talking to a healthcare provider at a distant location by two-way television.

What is the Generic Telehealth Network?

The Generic Telehealth Network is a regional network connecting approximately____ healthcare facilities within a ___ square kilometer radius and is home to ___ people. The network offers patients the opportunity to receive care closer to home for programs such as _____.

Telehealth will:

- provide access to specialized healthcare providers.
- decrease the time spent away from home and work
- save time, money and reduce some of the risks associated with travel.

How does Telehealth work?

The site coordinator will explain:

- how the equipment works
- the steps that have been take to ensure your privacy is maintained during the Telehealth Consultation/Examination.
- how your personal health information will be secured and maintained as part of your health record according to hospital, legislative and professional standards.
- the roles of the individuals present and introduce you to the individuals who will be present in the local site as well as those at the distant site.
- that you have the right to request that non-essential people be excluded from your Telehealth Consultation/Examination.
- why it is necessary to change into a gown if needed.
- that when you are satisfied your questions have been answered you will be asked to sign a consent form
- that if either you or your health care provider feels that the Telehealth appointment is not suitable for your condition there is an option to have an appointment arranged a the consulting location.
- will rebook your Telehealth appointment if there is an equipment failure.
- take the time to answer your questions.

What if photographs are needed?

The site coordinator or healthcare provider will explain Telehealth photography videography and/or audio recording. You will be asked to sign a separate written informed consent if you agree to have photography, videography and/or audio recording produced.

If you have any questions please contact your local Site Coordinator:

Coordinator: _____

Contact: _____

Phone/Email: _____

Required Elements for Consent to Treatment

The **required elements** for consent to treatment are:

a. the consent must relate to the treatment;
b. the consent must be informed;
c. the consent must be given voluntarily; and
d. the consent must not have been obtained through misrepresentation of fraud.

A consent to treatment is **informed** if, before giving it:

a. the person received the information about:
   I. the nature of the treatment
   ii. the expected benefits of the treatment
   iii. the material risks of the treatment
   iv. the material side effects of the treatment
   v. alternative courses of action
   vi. the likely consequences of not having the treatment that a reasonable in the same circumstances would require in order to make a decision about the treatment; and

b. the person received responses to his or her requests for additional information about treatment, benefits, material risks, material side effects, alternative courses of action and consequences of not having the treatment.

Informed consent must include who will be performing the treatment or procedure. It should also be made known to the patient that their treatment or procedure may involve Residents, Medical Students, and Clinical Fellows as part of their teaching experience. If a Clinical Fellow has independent operating privileges, without the assistance of the Consultant and is performing a procedure, it should be explained to the patient/SDM and the consent should reflect that.

Substitute Decision Maker (SDM)

Substitute Decision Maker (SDM) is defined as a person who is:

a. at least 16 years of age (unless he or she is the incapable patient's parent),
b. capable with respect to the treatment,
c. not prohibited by court order or separation agreement from having access to the incapable patient or giving or refusing consent on the incapable patient's behalf,
d. available, and
e. willing to assume the responsibility of giving or refusing consent.

In descending order of priority, an incapable patient's SDM may be:

I. the incapable patient's **"guardian of the person"**, appointed under the Substitute Decisions Act, 1992, if the guardian has authority to give or refuse consent to the treatment,

ii. the incapable patient's **"attorney for personal care"**, given under the Substitute Decisions Act, 1992, if the power of attorney confers authority to give or refuse consent to the treatment

iii. the incapable patient's **"representative"** appointed by the Consent and Capacity Board, if the representative has authority to give or refuse consent to the treatment

iv. the incapable patient's **spouse or partner**

v. a **child or parent (custodial)** of the incapable patient, or a Children's Aid Society or other person who is lawfully entitled to give or refuse consent to the treatment in the place of the parent

vi. a **parent (who has only a right of access)** of the incapable patient

vii. a **brother or sister** of the incapable patient

viii. **any** other relative of the incapable patient

ix. the **Public Guardian and Trustee**

Policy & Procedure - Consent to Patient Photography

Policy:

Patient photography, videography and/or audio recording during a Telehealth Consultation/Examination can proceed only with the informed written consent by the patient (if capable) or the substitute decision maker (SDM) (if the patient is incapable).

Purpose:

1. To ensure the patient/SDM understand why patient photography, videography and/or audio recording are required, how the images will be used, and how the images will be stored.
2. To ensure informed written consent is obtained from the patient/SDM prior to taking patient photographs, videography and/or audio recordings during a Telehealth Consultation/Examination or a media event.

Substitute Decision Maker (SDM) is the person responsible for decision making for an incapable individual (See Sample Documents).

Procedure:

1. The site coordinator, healthcare provider and/or media representative if applicable will provide a copy of the Patient Telehealth Photography Information Sheet and explain to the patient/SDM:
   - the purpose for taking the photographs, videography and/or audio recording during a Telehealth Consultation/Examination.
   - the equipment used to take the photographs, videography and/or audio recording.
   - the person who will take the photographs, videography and/or audio recording.
   - the implications of having the photographs, videography and/or audio recording taken.

2. The site coordinator will:
   - provide the opportunity for the patient to have their questions answered.
   - obtain informed written consent if patient/SDM agrees to have photographs, videography and/or audio recording produced.
   - ensure the original consent is in included in the patient's health record at the referring location
   - fax the consent to the consulting location for inclusion patient's health record.

3. Actual photographs, videography and/or audio recording will be clearly identified by the:
   - patient's full name.
   - date of birth.
   - health card number.
   - date taken.

4. Photographs, videography and/or audio recording taken for the purpose of documenting the patient's condition and/or facilitate patient care will be secured and maintained as part of the health record at the referring location and the consulting location if requested. A copy of the consent will be stored with the photographs, videography and/or audio recording to ensure the restrictions for use are observed and maintained.

5. Written informed consent is required for each photography, videography and/or audio recording event.

References:

Consent to Treatment Act, 1996.
Substitute Decisions Act, 1992.

Addressograph

Consent to Patient Telehealth Photography

1. I, _____ hereby consent to
   Patient / Substitute Decision Maker

   photography, videography and/or audio recording on _____
   Patient Name / Myself

   during my Telehealth Consultation/Examination for the purpose of

   - ❑ documentation of my condition and/or to facilitate my care
   - ❑ health education
   - ❑ research
   - ❑ media**
   - ❑ press conference**
   - ❑ public relations**

   ** I understand that members of the media are not associated with Generic Telehealth Network or _____and that photographs,
   Health Care Facility

   videography and/or audio recordings taken by the media remain the property of the media and may be used in the future for file footage.

2. Restrictions or limitations that I place on my photographs, videography and/or audio recordings and/or the use of the same are:

   _____

   _____.

3. _____ has explained patient photography
   Site Coordinator / Designate

   to me. I have read the Patient Photography Information Sheet and understand the information given to me. I have had the opportunity to have my questions answered to my satisfaction.

_____ (Date)

_____
Signature: Patient / Substitute Decision Maker

_____
Print name: Patient / Substitute Decision Maker

_____
(Relationship if signed by other than the patient)

PATIENT TELEHEALTH PHOTOGRAPHY VIDEOGRAPHY AND AUDIO RECORDING INFORMATION

The use of patient photographs, videography and/or audio recording during patient care is on the rise. New scopes and surgical equipment may provide the capability of routinely recording events on videotape or digital media. Physicians and hospitals increasingly use videotapes for seminars, teaching and community education.

Although patient photographs, videography and/or audio recording may be fairly common, patient rights need to be considered. Patients need to make an informed decision as to whether they wish to have pictures taken to document or assist with their care or for educational or research purposes. Patient permission is needed for photography, videography and/or audio recordings taken during a media or promotional event, press conference and/or during an interview.

Some common ways in which patient photography is used includes:

- demonstration of patient care.
- education of healthcare providers.
- research purposes.
- public relations (news stories, hospital promotions and publications).

Did you know?

- photographs videotapes and/or audio recordings of the Telehealth Consultation/Examination cannot be made without the patient or substitute decision maker's written informed permission.
- photographs videotapes and/or audio recordings by the media cannot be made without the patient or substitute decision maker's written informed permission.
- the purpose or the reason for the pictures needs to be explained.
- the patient can refuse to be photographed.
- the patient can authorize that their pictures are used for their treatment alone and the pictures cannot be used for education, training, research and/or media or promotonal events.
- the pictures made for their personal treatment will be secured and maintained as part of their health record.
- the consent form will be stored securely and restrictions placed on the use of the pictures will be noted in writing and stored with the pictures.

Do you have all the information you need?

If you have any questions about Telehealth photography, videography and/or audio recording please contact the Site Coordinator.

Coordinator: _____

Contact: _____

Phone/Email: _____

Appendix G - Summary of Action Items from Recommendations

Appendix G - Summary of Action Items from Recommendations

Issue	Action Items
Consent	• Eliminate written consent for general telehealth encounters • Obtain written consent for videotaping of clinical or educational sessions, patient photography, promotional/media events, collection of data for research or evaluation purposes, medical acts that would normally require consent, and possibly for new applications • Continue to engage risk management teams and legal counsel in development of consent policy • Provide more education on consent issues • Development of a position statement on telehealth consent • Develop guidelines/templates for information to be shared with patients and providers • Streamline consent process and integrate with pre-existing process/documentation
Registration, Documentation & Patient Records	• Work within existing processes, organizations, and initiatives • Conduct a more comprehensive review of current practice • Further define patient registration • Identify a minimal data set to ensure sufficient information is captured and maintained • Promote the electronic health record as an effective means of collecting, archiving and managing patient information related to telehealth • Raise awareness of other issues impacted by registration and documentation practices
Job Descriptions, Roles & Responsiblities	• Job descriptions, roles and responsibilities be considered a high priority area • Further define and detail the core competencies for Telehealth Coordinators and supporting staff • Perform a formal task analysis for Telehealth Coordinators and supporting roles • Determine how telehealth positions may best fit into institutional human resource frameworks • Identify priorities for professional development • Integrate telehealth with other e-health job descriptions • Share knowledge, lessons learned and tips with other coordinators across the country • Develop a formalized network of peers to provide information and support • Assess the risks and benefits of an accreditation or certification program for Telehealth Coordinators

Telehealth Awareness & Evaluation	• Develop a standardized process for evaluation • Set aside the necessary resources to ensure effective telehealth promotion and evaluation • Develop and integrate communications and evaluation plans at the start of the project • Continue evaluation beyond pilot phase • Design communications and evaluaton plans with the purpose, the audience, and 'best practices' in mind • Common evaluation indicators, tools and frameworks should be identified and made available • Develop a database of successful promotional and evaluation tools • Telehealth programs must share their knowledge and experience
Training	• Ensure there are sufficient funds, time and expertise allotted to training • Develop a consensus on minimal data set/core competencies to guide training content • Develop or access skills in technical training, procedural/process training, and clinical training • Ensure flexibility in content and delivery - Beware of the cookie cutter approach!! • Provide access to training courses outside telehealth • Develop and regularly update training manuals, quick reference guides and other tools • Engage the vendor community to work with the telehealth team in developing and delivering appropriate training that meet the specific needs of telehealth • Provide opportunities for telehealth programs to share successful training strategies and collaborate on developing new and innovative training programs • Ensure training is offered frequently and regularly
Other Interoperability Issues	• Telehealth Coordinators to educate and engage professional associations, policy and standards organizations, and other groups on cross-jurisdictional issues • Develop a position paper on cross-jurisdictional issues for government • Health Canada can play a role in working with telehealth experts and policy groups to resolve outstanding issues • The government can be pressured to resolve the cross-jurisdictional barriers to telehealth in order to fulfill the tenants of Canada's Health Act • Simple, consistent and replicable processes should be instituted wherever possible. • Liaise with other groups that may be able to assist in moving the cross-jurisdictional interoperability agenda forward • Capture an inventory of interoperability issues, successful strategies, templates for contracts and agreements, and other relevant information to advance our understanding of cross-jurisdictional issues and solutions

Appendix H - Workshop Evaluation Summary

Summary

'Report of the Evaluation of the Telehealth Coordinators' Workshop'

Introduction

The National Telehealth Coordinator Workshop 2002 Planning Committee decided that there would be value in obtaining documented feedback from the workshop participants. Evaluation of the expected outcomes of the workshop would shed some insight into lessons learned and would serve as a resource to assist with future planning of similar events. To this end, the Planning Committee developed a single page evaluation form. The information collected from the participants would provide qualitative evidence to the workshop Planning Committee in three key areas - workshop organization, participant expectations and suggestions for future workshops.

The evaluation form was distributed to all participants and clear instructions were given as to the importance of completing and submitting the forms at the end of the workshop. A total of 61 evaluation forms were completed and returned representing close to a 100% return rate.

The evaluation form was set up with a series questions in each key area.

1. Organizational, Expectations and Learning Factors
In the first section of this report, closed questions (forced choice) were asked. The questions covered three major aspects of the workshop: organizational and material aspects, participant expectations, and participant perceptions about learning and exchange activities

2. Participant Expectations
In the second section, participants' interest and topic suggestions for future workshop were solicited. This question included four nominal variables (yes/no) and for each items an open-ended question to record general comments.

3. Future Workshop Suggestions
In the third section, participants' were asked what they plan to change in their respective work as a result of the workshop. Responses were coded.

4. Methodological Note
Finally, a short methodological change for future evaluation forms was recommended.

Compilation and analysis using SPSS was done by a graduate student, Maria Eugenia Dominguez and results submitted to the Planning Committee for review. The following summary is taken from the report and should be considered by the reader as a "snapshot" of this report, highlighting specific findings. A copy of the complete report will be made available upon requests to the National Coordinator Workshop 2002 Planning Committee.

Report Highlights

1. Organizational Factors, Participant Expectations and Learning Factors

Organizational and material aspects of workshop

The participants were asked about their satisfaction relative to 10 variables (Table 1 from report). The most satisfactory aspects were speakers, organization, meeting facilities, contents and format. Handout materials were the least liked aspect of workshop.

Table 1
DEGREE OF SATISFACTION ABOUT ORGANIZATIONAL AND MATERIAL ASPECTS OF WORKSHOP
(%)

Variables	Valid Percent					Missing values (%) (No response)
	Very satisfied	Satisfied	Neutral	Unsatisfied	Very unsatisfied	
Meeting fac.	57.6	27.1	10.2	5.1	0	0
Speakers	54.1	39.3	6.6	0	0	0
Organization	49.2	44.1	5.1	1.7	0	3.3
Opp. To interact	44.3	37.7	13.1	1.6	3.3	0
Content	40.0	41.7	13.3	5.0	0	0
Ability to hear	39.0	47.5	11.9	1.7	0	0
Ability to see	36.7	43.3	16.7	3.3	0	0
Facilitation	34.4	50.8	11.5	0	3.3	0
Format	32.8	45.9	19.7	1.6	0	0
Handout materials	20.3	45.8	22.0	10.2	1.7	3.3

Using the numeric values for each variable, we can compare the mean results and standard deviation (Table 2)

*****

Participants' comments about organizational and material factors

Only 25 respondents commented on the general organization of workshops. The most positive comments were about the work of the organizers, general conditions (food and location), facilitators and promotion.

Critical comments were mainly about breakout session methodology: 12 people commented that summaries presented by session reporters were excessively long, included too much detail and were redundant. Some of the most notable responses include:

"Very well organised workshops. Congratulations to organisers for putting on such excellent workshops. Excellent food."

Organization really well done-forum for discussion. Excellent facilitators. Great info and promotion."

"Very disappointed that co-leads work not taken into more consideration during the breakout session. In the ...Summaries! People were saying one more time what was discussed, and action items and next steps were not emphasized. What is the point of all that? Just talking?" -

Additional comments centered on the amount of time assigned to informal exchanges between participants about their particular experiences in all locations (provinces).

- "Please make time at the beginning of the workshop for people to introduce themselves by name and telehealth project".

- "I would have liked to have had the opportunity to hear introductions by all participants. And also it would be great to hear about what is going on telehealth activities in each province".

Some of participants believe that working groups were much too heterogeneous and the number of topics included in discussions was excessive. Critical comments about the organization centered on the rooms, which were used for workshop discussions (too small for groups), the number of participants in each discussion group and necessity to have documents before presentations.

- "Bigger meeting room required next time".
- " It would have been helpful to have hard copies of the group leaders slides for the discussion group"

-"Please make the time longer (3 days)".

2. Participants expectations

Participants' expectations of the Telehealth workshop were divided, compared to the organizational aspects. (Table 3 from report)

TABLE 3
DEGREE OF SATISFACTION ABOUT EXPECTATIONS (%)

Variables	Exceeded	Met	Neutral	Somewhat less met	Not met	Missing values (%)
Promotion and evaluation TH	27.1	50.8	22.0	0	0	3.3
Consent guidelines	23.3	51.7	20.0	1.7	3.3	1.6
Human resource	16.7	51.7	30.0	0	1.7	1.6
Training requirements	16.1	50.0	28.6	3.6	1.8	8.2
Stand. Initiatives	11.5	54.1	27.9	1.6	4.9	0
Cross-jurisdictional	7.1	46.4	35.7	7.1	3.6	8.2
Patient registration	7.1	44.6	42.3	3.6	1.8	8.2

Learning and exchange activities: Most and least valuable aspects of workshop

The most valued learning and exchange facets are represented on Table 7 of the final report.

TABLE 7
MOST / LEAST VALUABLE ASPECTS OF WORKSHOP
(%)

Variables	Valid Percent					
	Most valuable	Valuable	Neutral	Not very valuable	Very Unsatisfied	Missing values (%)
Networking	59.0	26.2	13.1	0	1.6	0
Learning about challenges	42.6	42.6	13.1	1.6	0	0
Exchanging information about best practices	40.0	43.30	15.0	0	1.7	1.6
Learning about TH projects in Canada	27.1	35.6	28.8	8.5	0	3.3
Acquiring new knowledge	26.7	30.0	36.7	5.0	1.7	1.6
Contributing to development of national TH guidelines	25.4	42.4	25.4	3.4	3.4	3.3

Participant's comments about expectations

Sample open-ended responses about expectations:

- *"In one breakout session we introduced ourselves and said how we get involved in TH. I found this great because I realise that others are in the same boat".*

- *"Believe it will be valuable to learn what NIFTE does with national guidelines".*

- *"Become more involved in promoting telehealth among peers + adjunct professionals.*

- *"Networking has "opened my eyes" to the applications (endless) that are currently ingoing across the country - research application that can be applied to my region will be brought forward".*

- In question 5, participants were asked what they plan to change as a result of information gained in this workshop?". The thirteen topics which emerged most often:
  Promotion of TH
- Role of consents
- Strategic plan, management instruments
- Training practices
- Integrate best practices
- Integrate TH into hospital/health system
- Contacts with other TH experiences
- Communication plan
- Sustainability plan
- Integrate TH into community
- Technical issues
- Policy on registration
- Clinical case studies

some examples of comments follow.

Promotion:

- *"I leave with more information regarding promotion of telehealth and clarification of this role of consents. The discussion regarding the other issues (evaluation, interoperability) were interesting but I'm not taking away anything concrete from them".*

Role of consents:

- *"Review consent, training practices, promotion".*

-

Strategic plan/management instruments:

"Ill look at the organization structure within my program. How to divide up work, how to get more resources".

Integrate TH into hospital/health system:

-"Focus on the integration of telehealth in the present system".

Contacts with other TH experiences:

-"As a new TH coordinator it was excellent to network and meet peer contacts, be exposed to other programs and learn challenges that face all other provinces/territory. Learned a very valuable lesson in each workshop component, these lessons will now not be repeated".

Integrate TH into community:

"Rethink integration of training Coordinators in First Nations communities. Develop training program for telehealth coordinators that can be incorporated into training program that exist for community health representatives".

3. *Future Workshops Suggestions*

100% of the respondents plan to attend a similar workshop in the future and 85.2% stated they know others who can take advantage of such a workshop.

PARTICIPATION IN FUTURE WORKSHOPS
(%)

Variables	Yes	No	Missing values (NR)
Attend a similar workshop	100.0%	0	0
Willing to pay	62.7%	37.3%	16.4%
Interest in Planning committee	62.7%	37.3%	16.4%
Know others who benefit from such a Workshop	85.2%	14.8%	11.5%

Specific topics for workshops in the future

Topic suggestions have been grouped under eleven categories:

- Exchange Information Activities Across Canada
- Management
- Funding
- Training Resources
- Procedures and Protocols
- Program Planning
- Technical Issues
- Sustainability
- Clinical Issues
- Best Practices
- Consent

Some comments to exemplify respondent opinions:

"Training curriculum into academic programs for telehealth coordinators. Including some TH training hours into health professional training programs".

"Telehealth integration with other services; change management."

4. Methodological Note:

On the methodological side, it would be interesting, in the future, to include a question about the geographical origin and professional background of respondents, as some of the comments seem linked to specific local geographical or linguistic dimensions.

Closing Comments from the National Telehealth Coordinators' Planning Committee:

Upon review of the evaluation and the final report and the planning committees' experiences as a whole we would like to share closing comments. Recognizing the effort required to organize a national workshop the Planning Committee would like to submit some subjective observations and recommendations.

We were pleased with the end results of this event and also pleased to learn through the evaluation in addition to the verbal feedback that the participants found great value in participating and contributing to the activity of the workshop.

It is evident that there is a huge need for telehealth coordinators in Canada to formally network with their peers for the purpose of information sharing and support. The overall outcome of this two-day workshop was favourable as was reflected in the evaluation report. It is clear that there is still much work to be done in this area of Telehealth. As indicated in the evaluation report, 100% of the participants stated they would attend a future National Telehealth Coordinators Workshop.

The Planning Committee makes the following recommendation and actions:

1. As identified in the report, a "Special Interest Group" of front line telehealth users should be established under the umbrella of the Canadian Society of Telehealth.

This would allow those front line telehealth users to regularly rally as a group, to exchange and communicate information throughout the year as opposed to solely at National Conference time. The free flow of information would be encouraged and harnessed within CST, linking to existing committee structures.

Action: Chris-Anne Ingram will bring this recommendation t forward to the CST Board.

2. Leadership for the "body or Special Interest Group of Coordinators" must be established quickly. This newly established body, if interested would have the responsibility to explore, opportunities to seek and retain funding for an annual National Telehealth Coordinators Workshop and to develop the 2003 Planning Committee.

Action: The 2002 Planning Committee our committed to help support the transition to a 2003 Planning Committee.

3. Share lessons learned for planning

Many lessons have been learned in planning the 2002 Workshop.
In an effort to help facilitate these future workshops a planning template should be formulated to be used as a guide by the yearly planning committees. This tool would enable committee members to benefit from lessons learned and build on the successes of past conferences.
Such lessons would include:

- # To streamline travel expenses etc. the workshop should be held each year in conjunction with the CST. This has successfully occurred the last two years.
- # Maintain the attendee numbers at approximately sixty. It was noted in the evaluation report that this small number was easily rotated through the workgroups. Perhaps each health region or telehealth project to be invited could rotate or expose their participants on a yearly basis.
- # Ensure strong facilitation is secured, break out sessions report format
- # Ensure action items and next steps employed

Action: Resources should be allocated to facilitate the development of a planning template.

4. Future workshop budgets allocate resources to support the workshop planning and organization, which should include reimbursement of Planning Committee for costs incurred with work associated with workshop, and preparation/distribution of handout material.

Action: Planning Committee Members 2002 will provide to Planning Committee 2002 to help with the development of financial proposal for future workshops.

Programme de recherche sur les politiques en matière de santé
Résumé du rapport final

Titre :	**Atelier national 2002 des coordinateurs en télésanté 1er – 2 octobre 2002, Sheraton Wall Centre, Vancouver (Colombie-Britannique)**
Nom du chercheur :	**Madame Jocelyne Picot**
Date de la fin du projet :	**Décembre 2002**
Catégorie de recherche :	**Atelier**
Institution :	**Communications Infotelmed Inc.**
Numéro du projet :	**6795-15-2001/4430009**

Résumé

L'atelier national de 2002 des coordonnateurs et coordonnatrices de Télésanté s'est déroulé au Sheraton Wall Centre, à Vancouver, les 1er et 2 octobre 2002. Soixante coordonnateurs et coordonnatrices de Télésanté, invités à y participer, représentaient toutes les régions du pays. Durant l'atelier de deux jours, on s'est attardé à combiner les lignes directrices et les outils pour aider à la prise de décisions, à promouvoir les meilleures pratiques et à améliorer l'uniformité et l'efficacité de la prestation des services de TéléSanté. On a réuni l'information suivante sur chacun des six sujets au programme :

- Meilleures pratiques/lignes directrices – approches communes et réussites
- Leçons apprises – ce qui n'a pas marché et pourquoi
- Processus communs pour l'élaboration de politiques/lignes directrices
- Incidences pour une approche nationale
- Questions en suspens/Contraintes
- Mesures à prendre/Étapes suivantes

Le rapport donne un sommaire des recommandations formulées par les participants et participantes à l'atelier ayant trait au consentement aux services de TéléSanté; à l'inscription des patients, à la documentation et aux dossiers pertinents; aux descriptions de tâches, aux rôles et aux responsabilités; à la connaissance et à l'évaluation des services de TéléSanté; à la formation relative à TéléSanté; et aux questions d'interopérabilité. Le

compte rendu au complet de l'atelier et un sommaire des mesures à prendre qui sont issues des recommandations sont présentés en annexe du rapport final.

En plus des recommandations sur l'élaboration de lignes directrices concernant chacun des sujets, l'atelier national de 2002 des coordonnateurs et coordonnatrices de TéléSanté a permis d'en arriver à d'importantes constatations. Mentionnons la nécessité d'avoir plus d'information/de consultation dans les domaines prioritaires spécifiques; d'échanger plus d'information entres les programmes/projets de TéléSanté; de profiter davantage des possibilités de réseautage parmi les coordonnateurs et coordonnatrices de TéléSanté; d'avoir une 'voix' représentant les coordonnateurs et coordonnatrices de TéléSanté; et de définir clairement les voies à emprunter pour faire avancer les dossiers et les mesures à prendre. Pour maintenir l'activité et l'élan du groupe de coordonnateurs et coordonnatrices de TéléSanté, on a proposé les initiatives suivantes que l'on devrait considérer ou évaluer en fonction de leur valeur et de leur faisabilité :

- La création d'un groupe officiel de coordonnateurs et coordonnatrices de TéléSanté dans le cadre de la Société canadienne de TéléSanté (SCT)
- La création de groupes d'intérêt spécial ou de travail
- L'utilisation d'un site Web et d'autres technologies pour faciliter le réseautage entre les coordonnateurs et coordonnatrices
- La participation des coordonnateurs et coordonnatrices de TéléSanté dans les sous-groupes pertinents d'autres organisations professionnelles [c.-à-d. l'Association des infirmières et infirmiers du Canada (AIIC)]
- L'organisation d'ateliers de coordonnateurs et coordonnatrices de TéléSanté dans l'avenir

Les opinions exprimées ici ne représentent pas nécessairement le point de vue de Santé Canada

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En plus de ce résumé, vous pouvez obtenir le rapport des deux manières décrites ci-dessous.

- La version papier du rapport final complet est disponible dans la langue de soumission à la bibliothèque de Santé Canada, par prêt entre bibliothèques.
- La version électronique du rapport final est disponible sur demande dans la langue de soumission. Pour l'obtenir, écrivez à Santé Canada à l'adresse suivante : rmddinfo@hc-sc.gc.ca

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